



Innovation *through* Change

Grayson Clamp was among the first children in the United States to receive an auditory brainstem implant.

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MacNider Hall, the first building constructed as part of the medical school complex.

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Innovation *for* the Future of Health Care

Health care is changing more rapidly than ever. Growth and innovation are essential for health care organizations to effectively meet the challenges that change presents. As we reflect on the past year, it is clear that UNC Health Care is striving toward change that advances our mission.

We continue to collaborate with our partners and leaders across the state on innovations that will allow us to meet the challenges of the future. Change is both a challenge and an opportunity to connect our guiding principles to the advancements that lead us into the future. Our partnerships with other hospitals across the state, our advances in the way we deliver care and our efforts to train the next generation of our state's physicians position us well to lead.

This Annual Report features stories about how we are changing for the benefit of all North Carolinians. Our commitment to innovating for the patients we serve and the quality of care we provide is unwavering, no matter what demands tomorrow brings.

ACCOMPLISHMENTS

Advances in care, teaching and research

would not be possible without the talented individuals who make up our organization. UNC Health Care, its affiliate hospitals, physician networks and the UNC School of Medicine have all earned recognition for their hard work.

Rex Healthcare in Raleigh and Pardee Hospital in Hendersonville were each honored with an "A" hospital safety score by the Leapfrog Group. This is evidence of our commitment to provide better, safer care to our patients.

UNC Hospitals earned advanced certification from The Joint Commission and the American Heart Association/American Stroke Association as a Comprehensive Stroke Center. UNC Hospitals is one of only 15 hospitals in the country and the first hospital in the

Southeast to receive the designation.

UNC Hospitals was designated a U.S. News & World Report Best Hospitals top-50 facility for cancer (#43), gynecology (#44), and ear, nose and throat (#22). We also were recognized as "high performing" in eight specialties:

- cardiology and heart surgery
- diabetes and endocrinology
- gastroenterology and GI surgery
- geriatrics
- nephrology
- neurology and neurosurgery
- pulmonology
- urology

We were among 147 facilities—roughly 3 percent of more than 4,800 hospitals analyzed by the publication—to be ranked in at least one of the 16 specialties.

The UNC School of Medicine, with its campuses in Chapel Hill, Asheville and Charlotte, also was recognized nationally as a leader in medical education.

The School was ranked No. 1 in the country for Primary Care by *U.S. News & World Report*. We are particularly proud of this accomplishment, because we have redoubled efforts to emphasize the importance of primary care physicians.

In North Carolina, the physician-to-patient ratio continues to dwindle, particularly in rural and underserved areas. Our state ranks in the lower half of the country—with fewer than five physicians for every 100 residents. We are hopeful that our School's excellent ranking will continue to attract the best students to train and practice medicine in our state.

The School also was ranked #6 overall and #22 for Research and was recognized for Family Medicine (#2), Rural Medicine (#5) and AIDS (#9)—leading in crucial programs that make a real difference in our patients' lives. In a time when research dollars are scarce, the School contributed \$391 million in 2012 research funding, which is more than half of all funding for research at the University of North Carolina at Chapel Hill.

INNOVATION IN CARE

We continue to investigate new opportunities to support our mission to improve access to and delivery of care throughout the state. One such example is our assumption of administration of the WakeBrook Campus in Raleigh, a crisis care facility that was previously operated by Wake County.

WakeBrook helps us ensure patients seeking mental health services have greater access to a high-quality, streamlined care experience, all while alleviating the burden on local emergency departments. The campus officially reopened under our management in September 2013, with a 16-bed inpatient mental health wing similar to the psychiatric unit we run at UNC Hospitals. We also have committed \$10 million to enhance Wake

County's outpatient mental health services, and we have plans to develop and operate at least 12 more inpatient psychiatric beds in the area.

WakeBrook and our larger efforts to improve mental health in Wake County provide much-needed services to a fragile and important population. We believe this model can be adapted throughout the state to enhance and coordinate the needs of those requiring behavioral health services.

We also recently finalized a partnership between two of the state's top cardiology practices to form North Carolina Heart & Vascular. The combination of two longstanding practices in central and eastern North Carolina brings together long histories of providing excellent care and realizing successful outcomes for thousands of patients every year.

North Carolina Heart & Vascular has nearly three dozen physicians working out of 10 counties who will work together to improve patient care and outcomes and to conduct the type of ground-breaking research that leads to cures. The new partnership also will focus on improving access to specialized cardiovascular care for patients—all while making efforts to streamline care to keep costs down.

LOOKING FORWARD

As provisions of health care reform continue to roll out, we are making our best efforts to guide patients and employees through change. We are the only hospital system in North Carolina to provide assistance to patients seeking to enter the health insurance marketplace. We placed certified navigators in each of our markets to ensure that patients have access to enrollment information and opportunities to enroll.

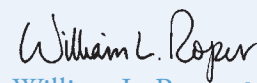
We are placing an increased emphasis on patient-centered care and primary care medical homes as the foundation for health care delivery. We will continue to improve our efforts to focus on wellness, prevention and highly effective chronic disease care. Our partners across the state are helping

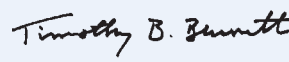
expand access to these types of services. Also, patients are benefiting from a collaborative approach to health care that connects communities with the health care resources they need, provided by the hospitals and doctors they trust.

As the state's flagship health system, we are in a position to lead not just our own colleagues and patients but people from around the nation. Despite a shifting health care environment, our faculty and staff stand ready to set an excellent example for innovation in research, teaching and care.

On behalf of our System, thank you for your support. You make it possible for us to meet our mission and to serve the people of North Carolina.

Sincerely,


William L. Roper, MD, MPH
Chief Executive Officer
The University of North Carolina
Health Care System


Timothy B. Burnett
Chairman, Board of Directors
(November 2012–Present)
The University of North Carolina
Health Care System







UNC Health Care System Update

After more than 60 years, UNC Health Care has evolved into an interdependent organization including hospitals, the medical school, physicians, nurses, researchers, teachers and students. Together, they form a cohesive whole that is better able than ever to fulfill its state-mandated mission of providing quality patient care, training physicians and health care professionals, and advancing innovative research to advance medical care.

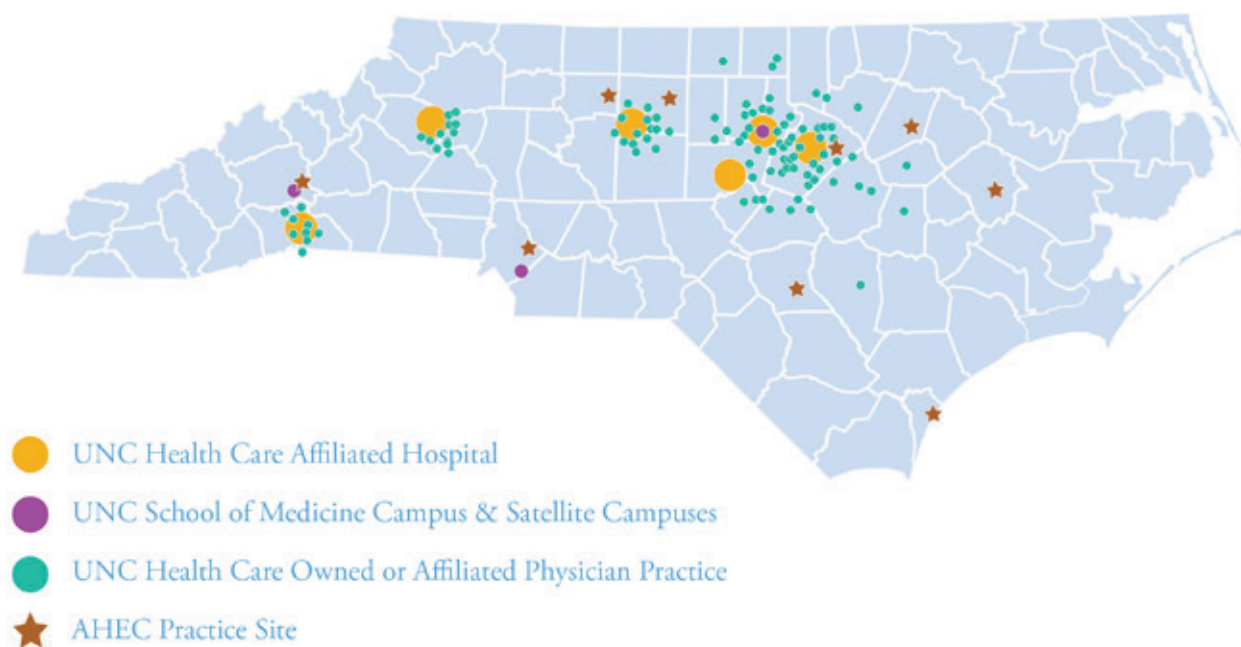
UNC Health Care has grown from a two-year medical education program and one state-built hospital into a School of Medicine with the nation's top-ranked primary care training program, and a five-hospital complex in Chapel Hill, with strong partnerships with dozens of hospital and physician affiliates.

GROWING TO GREATER SUCCESS

Despite the extensive growth within the system, UNC Health Care has never wavered in its determination to fulfill its core mission of providing quality patient care to the people of North Carolina, educating tomorrow's physicians and health care professionals, and conducting groundbreaking research that will help find cures to some of the world's most devastating diseases.

Patient Care: UNC Health Care constantly strives toward quality care improvements for patients. Currently, UNC Hospitals is piloting an innovative nutrition program designed to educate cardiovascular patients in heart-healthy eating habits and slowly transition them to a low-fat, low-sodium diet over a period of several weeks. If successful, the program will create an environment that fosters long-term patient health and well-being through education and collaboration. This program is the first of its kind in the nation and is just one example of the many ways that UNC Health Care is leading the field in providing quality patient care.

UNC Health Care Across the State



Teaching: The UNC School of Medicine is ranked first in the nation for primary care and 22nd for research, according to *U.S. News & World Report*, with several hospital specialties also receiving high rankings. More than 3,200 UNC School of Medicine graduates are currently practicing in the state of North Carolina.

Research: The UNC School of Medicine was among the nation's top 15 recipients of National Institutes of Health (NIH) funding in 2013, according to the Blue Ridge Institute for Medical Research. Our researchers use this funding every day to further the efforts in their respective fields to make groundbreaking discoveries, including such successes as the recent discovery of key enzymes which may have a profound effect on the development of autism.

THE YEAR IN REVIEW

In 2013, UNC Health Care dedicated personnel and financial resources toward the implementation of an integrated software system by Epic for UNC Hospitals, Rex Healthcare in Raleigh and Chatham Hospital in Siler City. The Epic electronic medical record (EMR) system will allow UNC Health Care to integrate a number of separate clinical and administrative programs, connecting the different hospitals' clinical and financial systems for medical records, registration, pharmacy and other uses.

When fully implemented, Epic will provide a full financial, scheduling, clinical and patient portal for UNC Hospitals, Rex Healthcare, Chatham Hospital, the UNC School of Medicine, UNC Faculty Physicians and UNC Physicians Network. Through

this integration, the entire UNC Health Care system will be able to coordinate data and improve service to both patients and providers.

In addition to streamlining internal systems, UNC Health Care has been dedicated to expanding quality patient care throughout North Carolina. Perhaps the most significant achievement of the past fiscal year lies in an agreement between UNC Health Care and the Wake County Board of Commissioners to manage the WakeBrook Campus, a crisis care facility previously operated by Wake County. Last spring, UNC Health Care began managing WakeBrook, which includes a crisis and assessment clinic, facility-based crisis unit, addiction treatment center, and acute inpatient unit. The Department of Psychiatry additionally operates a nearby outpatient clinic and an Assertive Community Treatment team provides mobile, on-call services to other patients in the community. A primary care clinic is also being established on campus as part of WakeBrook's mission to have comprehensive patient care on-site for both mental and physical health. UNC Health Care's collaborative approach to patient care and its management of these programs provides a higher level of services locally for both mental health and substance abuse needs.

While assuming the management of the WakeBrook Campus was a significant undertaking, it was not UNC Health Care's only expansion of the year. On July 1, 2013, UNC Health Care opened the Hillsborough Medical Office Building, which is a new 60,000-square-foot facility. It is the first piece of UNC Health Care's Hillsborough Campus and offers services from both UNC Hospitals



and UNC Faculty Physicians. These services include dermatology and skin cancer, GI medicine and procedures, women's care, pelvic health, urology, imaging, oncology, and laboratory services. The hospital at Hillsborough Campus is scheduled to open in 2015.

In August of 2013, Wake Heart & Vascular Associates and Rex Heart & Vascular Specialists formed North Carolina Heart & Vascular, a new physician group focused on improving access to specialized cardiovascular care for patients throughout central and eastern North Carolina. The group employs nearly three dozen physicians who work out of 19 offices spread throughout 10 different counties. They work closely with colleagues at UNC Hospitals in order to provide exceptional patient care to the people of North Carolina while simultaneously offering ease of access to those who may not be able to make it to UNC Hospitals in Chapel Hill.

"By partnering with others to improve access to care in North Carolina, we can mitigate the challenges of the future and improve the overall health of our communities," said William L. Roper, MD, MPH, CEO of UNC Health Care. "UNC Health Care does not do this alone. We have partners across the state who connect communities with the health care resources they need, provided by the local hospitals and doctors they trust."

In conjunction with the goal of spreading patient care throughout North Carolina, UNC Health Care has made it a top priority to expand medical education opportunities. According to the North Carolina Health Professions Data System at the Cecil G. Sheps

Center for Health Services Research, North Carolina retains about 40 percent of medical students educated in-state. However, the retention rate of primary care doctors is lower. With the population of North Carolina growing and aging, it is estimated that a 20 percent increase in primary care doctors is needed during the next 25 years to meet rising demand.

In an effort to meet this growing need, the UNC School of Medicine increased the number of medical students by 12.5 percent from 2010 to 2012, admitting 180 out of more than 5,000 applicants in 2012. In addition, the School now has satellite campuses in Asheville and Charlotte where students can spend their third and fourth years gaining experience while working with primary care physicians in underserved areas.

Despite growth and an extensive internal undertaking to upgrade necessary technology, UNC Health Care has remained committed to its mission of providing quality patient care to North Carolinians.

"We are an integrated and collaborative system," said Dr. Roper. "UNC Health Care is the state's flagship health system and, as such, is committed to fulfilling our mission to the benefit of patients across the entire state."



Unique Partnership Fills a Need *in* Mental Health Care

The closure of the state's mental health hospital, Dorothea Dix, in Raleigh had a significant impact on Wake County's mental health population, and county officials turned to UNC Health Care and other hospitals for help.

UNC Health Care began managing the WakeBrook Campus last spring as part of a new partnership with Wake County. WakeBrook is a county facility previously operated by the county that provides a range of services.

"It would have been a real challenge for us to operate WakeBrook," said former Wake County Manager David Cooke. "We're not a hospital, and we couldn't provide this level of services. This partnership with UNC puts us in a position to provide the best possible care for mental health patients in Wake County—better than anywhere else in the state, I would say."

Each month, about 400 patients are seen at WakeBrook's crisis and assessment clinic, which is a 24-hour facility available for patients in crisis on a walk-in basis. The campus also houses a residential, facility-based crisis unit, which has 16 beds for patients, as well as a 16-bed residential addiction treatment center. Another building holds a 16-bed acute inpatient unit, operating as part of UNC Hospitals' inpatient psychiatric unit, with another 12 beds to be added in the future. In addition, the Department of Psychiatry operates an outpatient clinic nearby for some of the most fragile population and an Assertive Community Treatment team provides mobile, on-call services to support other patients living in the community.

Amy Jordan, BSN, RN-BC, nurse manager of the acute inpatient unit, said there is a clear need in Wake County for mental health beds and a tightly coordinated plan of care for patients.

"We are going to do some wonderful things here," Jordan said. "The most exciting part is that we are a great resource for mentally ill patients in an environment where there are few resources. We are building a best-practice model for psychiatric care and making it possible to do innovative things to help patients."

One innovation that is central to WakeBrook's mission is having comprehensive patient care on site for both mental health and physical health. On average, people with severe mental illnesses die 25 years earlier than the general population, often due to lack of medical treatment for common physical problems, most of which



Brian Sheitman, MD, medical director of WakeBrook, left, with Aldona Wos, MD, secretary of the North Carolina Department of Health and Human Services, center, and William L. Roper, MD, MPH, CEO of UNC Health Care.

can be prevented, according to the National Association of State Mental Health Program Directors.

A primary care clinic is being established on campus to provide a full scope of medical services for WakeBrook patients and their families. This concept—called *reverse* co-location—is rare in the mental health system. Under a far more common arrangement called *co-location*, therapists and other mental health personnel come into a medical setting or are available in a general practice. *Reverse* co-location makes it easier for mental health patients to get the medical care they need but often go without.

“Having a medical office onsite means patients at WakeBrook can receive preventive care, acute services and other care, just like a regular doctor’s office, in a familiar setting they trust,” said Beat Steiner, MD, MPH, professor in the Department of Family Medicine at the UNC School of Medicine, who will run the medical clinic when it opens. “It allows us to take care of the whole person’s needs.”

COLLABORATION PROVIDES POSITIVE RESULTS

This holistic approach to patient care is supported by WakeBrook’s collaborative nature. Four UNC School of Medicine clinical departments are involved in providing care: psychiatry, emergency medicine, family medicine, and obstetrics and gynecology. Medical services have been expanded to include mobile radiology services, such as on-site electrocardiograms, which are more commonly called EKGs. A treatment team of doctors, nurses, social workers, therapists and case managers work together to go beyond providing care in the facility. The care team also provides extensive planning and follow-up for after-care.

“I’ve been impressed by the level of interdisciplinary teamwork and the effort in setting up patients to succeed outside the hospital,” Jordan said. “To see the progress our patients are making from when they get here to when they leave is amazing.”

Brian Sheitman, MD, medical director of WakeBrook, says collaboration and innovation are critical to providing the best quality of care for patients. “Too often, the mental health system is focused on access to care but not the quality of care. Every day we ask, ‘What can we do better?’ We want to test out new ideas, see how they work, and decide if they are feasible to implement. With quality comes innovation.”

Hospitals Team Up to Transform EMS for Mental Health

Since UNC Health Care agreed to assume responsibility for WakeBrook, local hospitals and other service providers have participated in coordinating care for mental health patients across Wake County.

The group proposes to transform the delivery of health care services, with a special focus on emergency medical services (EMS), for patients with serious mental illness. They envision an advanced practice paramedic (APP) program and payment plan for EMS as part of an integrated behavioral and physical health care system. They hope to improve the quality of care for severely mentally ill patients and to reduce the total cost of care.

Patients with severe mental illness also have high rates of medical illness, and account for 20 percent of total health care costs. The current system for treating these patients is both fragmented and reactive, relying on expensive and often ineffective interventions, such as emergency department visits, hospitalization or incarceration, only after a medical or mental health crisis has already occurred.

Under the proposed model, EMS would be leveraged to provide both rapid de-escalation and prevention of mental health crises. The first step would provide more cost-effective treatment for patients by using community-based APPs to respond to all 911 behavioral health emergencies and to provide direct transport to crisis and assessment services in each county, instead of local emergency departments. APPs also will support an integrated health home through mobile outreach, including ongoing home-based medication monitoring and assessment.

The second step would create two health homes that fully integrate mental health and primary care for these patients within existing community mental health settings at WakeBrook in Wake County and Durham Center Access in Durham County.

The group plans to partner with dozens of other health care providers, advocacy organizations, and public safety departments in Wake and Durham counties, along with the community-based care management services Alliance Behavioral Healthcare and Community Care of North Carolina (CCNC).

The initial feedback has been very good, and the group believes that will lead to grant funding to expand the work, both in Wake County and throughout the state.

The residential, facility-based crisis unit represents another opportunity for innovation. Although detox is the most significant need within the unit, it can also function as a middle ground of care for mental health patients, similar to the kind of coordinated, multi-level care that regularly occurs for medical patients.

“Why shouldn’t psychiatric care function like other specialties do?” asked Laura McDaniel, clinical supervisor at WakeBrook, who likens facility-based crisis to a general hospital bed and the acute inpatient care unit to a hospital intensive care unit.

Facility-based crisis, McDaniel said, can serve as a step-down unit so that patients with severe behavioral problems can be admitted to the acute care inpatient unit until they are stabilized, then move into facility-based crisis for a few more days before discharge. The unit also can serve as a step-up unit for substance abuse patients who might need longer-term treatment than other patients at the addiction treatment center.

ENGAGING PATIENTS IN THEIR OWN CARE

One commonality at all of WakeBrook’s units is the role of the patients in their own care. Treatment teams hold interactive group and individual meetings with patients, ask for their feedback, incorporate patients’ goals into their treatment plans, and use exercises that help patients understand how their family, friends and associates can influence their health.



Beat Steiner, MD, MPH

“The only way a person can change their behavior is if they desire to do so,” said Dr. Steiner, adding that the feedback he receives about WakeBrook from patients has been extremely positive.

Patient care across the campus is coordinated through daily huddles and formal monthly meetings, as well as more frequent, informal conversations with other

Wake County hospitals, service providers and agencies. Referrals to all programs are reviewed every day, referrals are actively pursued, and follow-up phone calls are commonplace.

“We partner with community and mental health advocates to assure that the care and services we provide at WakeBrook meet the needs of our patients,” said Paula Bird, WakeBrook’s administrator. “We talk almost daily, both within the facility and with other hospitals and care providers. Having all the main hospitals in Wake County pulling in the same direction means better coordination of services and ultimately better care for patients.”

The level of collaboration has been significant, including UNC Hospitals, Rex Hospital, and Duke Raleigh Hospital, while WakeBrook’s partnership with local emergency departments and Wake County Emergency Medical Services System has led to a more effective approach for handling patient calls.

“We started out trying to figure out how to work together to improve services for patients, and it has grown into a real collaborative partnership,” said Tammie Stanton, RN, UNC Health Care’s vice president for Post Acute Services.

LOOKING TO THE FUTURE

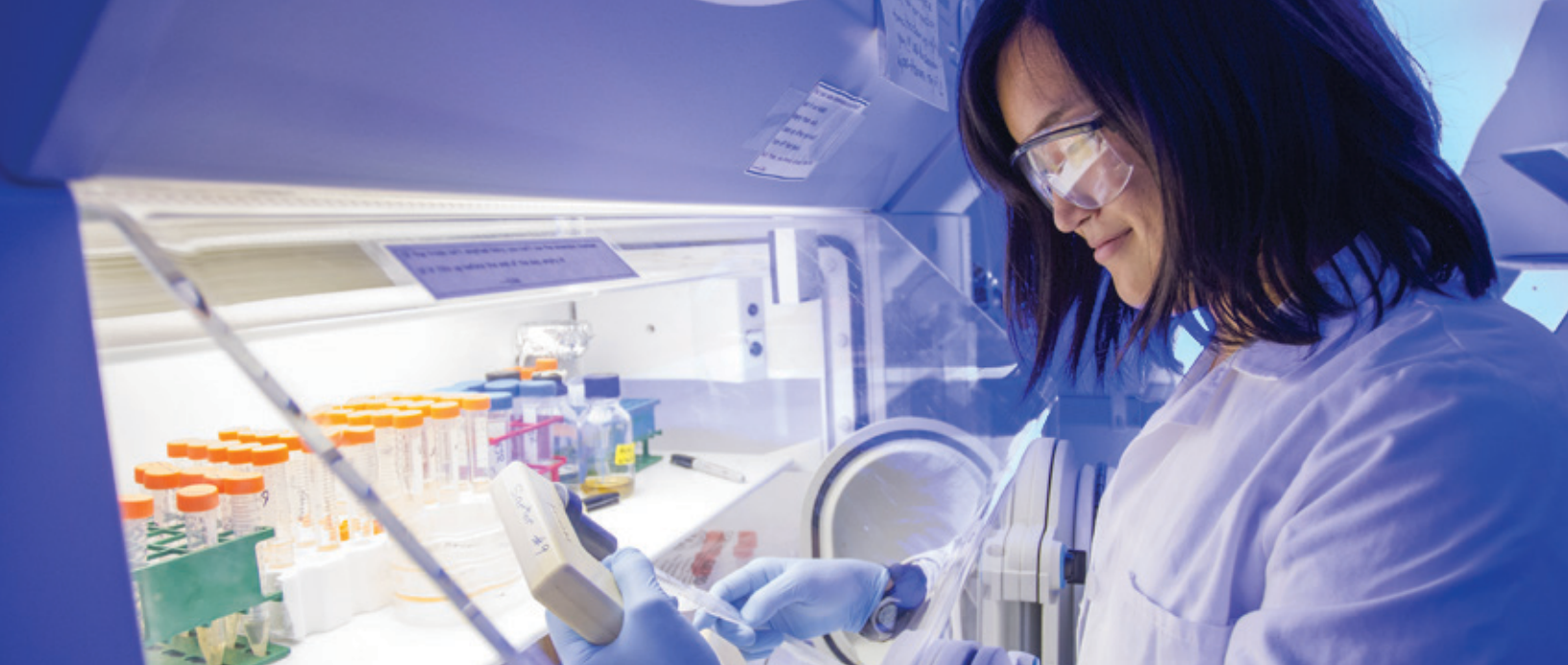
David Cooke, who retired in November after 14 years, said these kinds of partnerships were a long time coming. North Carolina’s evolving efforts to reform the mental health system date back decades, leading to a reduction in mental health beds and a shift toward counties and local management entities coordinating community-based services.

Wake County supports 44 inpatient beds to care for Wake County residents at Holly Hill Hospital in Raleigh, but determined that more resources were needed for this population, including less acute facilities. The County moved forward with building the WakeBrook campus, while continuing to communicate with UNC with hopes of partnering to provide services in the future. Today the County provides more than \$10 million annually for care at WakeBrook, where many of the patients are indigent and uninsured.

Dr. Sheitman, a longtime behavioral health clinician, said it is difficult for patients and their families to navigate a fragmented mental health system that too often separates providers from each other. WakeBrook is trying to break that mold by bringing providers together, and, in turn, improving the quality of patient care.

“Our role is to be public servants who provide services to the community,” Dr. Sheitman said. “These aren’t ‘our’ beds—they don’t belong to us. We have to adjust to what the public wants and what our patients need. The goal of everyone here is just to get better.”

For Dr. Steiner, working at WakeBrook means being involved in launching a way of caring for the mental health needs across the state. “It’s the opportunity to build something that others can use as a model,” he said. “We can be creative and really make a difference for people, and it’s exciting for everyone. This could be the wave of the future for mental health care.”



Academic Medicine Advances Patient Care

Research is a critical part of the mission of UNC Health Care, and its reputation as an outstanding academic medical center benefits many. Patients have access to the latest treatment options and technologies, while ongoing clinical trials and research stand to result in better care for future patients. Doctors and researchers have access to clinical and lab space, a growing clinical trials network, and the opportunity to collaborate on cutting-edge research that can accelerate efforts to understand, treat and eradicate disease.

This year UNC Health Care was home to a number of exciting research advances. Within the coming months, a team of UNC scientists will start testing the first bionic pancreas, which could lead to major improvements in diabetes management. After the first pediatric auditory brainstem implant conducted in an FDA-approved trial in the United States, a 3-year-old has gained the ability to hear sound for the first time and is now developing speech. Also, a significant discovery about the genetic development of autism has given UNC researchers new insights to pursue about environmental factors that contribute to autism.

Research Teamwork Vital as Resources Grow Scarce

Mark Zylka, PhD, and Benjamin Philpot, PhD, pooled their research funding grants to buy the high-powered genetic sequencing machine that led to their autism discovery. This is just one example of how shared equipment and other core facilities have fostered collaboration among university researchers.

Sharing resources is becoming even more vital as traditional research funding sources, both public and private, have declined or remained flat due to economic pressures. For example, last fiscal year, the National Institutes of Health estimated that it would fund around 20.3 percent fewer research project grants than it did a decade ago. Despite the decline in overall funding, faculty at UNC continue to leverage more research dollars than many public and private peers, being awarded nearly \$800 million in total extramural research funding last year.

“Research is really important to benefit the economy, develop new technology and advance new ideas,” Dr. Zylka said. “Grant writing has always been critical for research, but if scientists are spending a lot more of their time writing grants, there is less time to do the groundbreaking work they were trained to do.”

NEW CLUES IN THE HUNT FOR AUTISM CAUSE

While studying a chemotherapy drug’s effect on a genetic disease called Angelman syndrome, UNC professors unexpectedly discovered a link to autism, unveiling a new path of research on possible environmental causes as incidences of the disorder continue to rise.

Mark Zylka, PhD, associate professor, and Benjamin Philpot, PhD, professor, both in the Department of Cell Biology and Physiology, published their results in the journal *Nature* last August. Their research centers on enzymes called topoisomerases that untangle DNA during key biological processes such as cell division and gene expression.



The chemotherapy drug topotecan inhibits topoisomerase I to halt tumor growth. Drs. Zylka and Philpot began investigating how the drug affects these enzymes and gene expression in people with Angelman syndrome, and they began testing nerve cells treated with topotecan. They found that topotecan had the most notable suppressive effects on genes that were exceptionally long, including nearly 50 long genes that have been linked to autism. This led to their insight that inhibiting topoisomerases might increase the risk of autism.

The next step is to run hundreds of other chemicals and compounds through similar testing, looking for more substances that inhibit topoisomerases. “If there are additional compounds like this in the environment, it becomes important to identify them,” Dr. Zylka said. “That’s motivating us to move quickly to identify other drugs or environmental compounds that have similar effects so pregnant women can avoid being exposed to these compounds.”

UNC is ranked one of the top universities in the world for research in autism, which affects 1 in every 50 children. Dr. Philpot credits this latest discovery in part to the involvement and collaboration of several UNC researchers and their labs. “There are so many different people working together to try to really push the envelope,” he said. “That type of environment is amenable to making a big discovery.”

CLINICAL TRIAL OFFERS LIFE-ALTERING SURGERY FOR 3-YEAR-OLD BOY

Grayson Clamp, who was born without the auditory nerve in each ear that connects the cochlea to the brain, was among the first children in the United States to receive an auditory brainstem implant (ABI). The surgery was part of a clinical trial approved by the Food and Drug Administration (FDA) under a protocol



developed at the UNC School of Medicine. An ABI is a surgically implanted electronic device that allows sound to travel from the environment to the brain, bypassing the absent hearing nerve.

The device has been used before in adults as well as in children older than 12 with neurofibromatosis type II (NFII), a condition that causes tumors to grow on the cochlear nerve. It has only been during the last decade that it was made available in Europe to children without nerves. ABI clinical trials in children were not approved in the United States until August 2012 at UNC.

Nine months after the surgery by Craig Buchman, MD, FACS, division chief of Otolaryngology/Neurotology and Skull Base Surgery, and Matthew Ewend, MD, FACS, chair, Department of Neurosurgery, Grayson not only can hear but is continuing to develop his own words.

“He’s making slow and steady progress, which is what we expect,” said Dr. Buchman, “and overall his progress is really good. He certainly hears and has environmental awareness. It’s not the same trajectory as a cochlear implant, and only time will tell where we end up.”

Drs. Buchman and Ewend spent more than seven years getting several layers of approvals for the clinical trial. When Grayson was about 18 months old, Dr. Buchman inserted a cochlear implant. His family and his doctors knew the implant would likely not work because Grayson lacked auditory nerves. However, the cochlear implant was required by the FDA as a necessary step toward an ABI. After the cochlear implant failed, Dr. Buchman spent nearly two more years getting Grayson approved for the ABI trial.

The trial at UNC Health Care focuses on children under age 5 who have not had NFII, and for whom cochlear implants have not been effective. It is one of multiple ABI clinical trials occurring in the United States, but the success of Grayson’s implant has given UNC’s trial an international following—due in part to a video of his reaction to hearing his dad’s voice for the first time, which went viral through online social media.

“We are getting inquiries from all over the world,” Dr. Buchman said. The second and third patients in UNC’s trial live in Tennessee and North Dakota, respectively, and he has seen potential patients from Texas, Kansas, Michigan and Illinois.

Dr. Ewend said Grayson’s surgery is one of the single most exciting things he’s done in his career. “It really was amazing to be part of bending the curve of this family’s life,” he said.

To learn more about Grayson’s story and see videos of his progress, visit <http://uncmedne.ws/grayson>.



New Leadership and Unique Programs Show Continued Promise *for* the Future of the Department of Allied Health Sciences

The implementation of the Patient Protection and Affordable Care Act and the shortage of primary care doctors are changing the way health care is being delivered. UNC Health Care is addressing both of those challenges and working to help the approximately 4.5 million people living in North Carolina who do not have adequate health care, according to the North Carolina Office of Rural Health and Community Care.

One effort toward that goal is a new physician assistant (PA) master's degree program currently under development in the Department of Allied Health Sciences (DAHS) in the UNC School of Medicine.

"The mission of this program is to prepare skilled and compassionate physician assistants, committed to addressing the health care and workforce needs of North Carolina and the nation," said Prema Menezes, PhD, PA-C, director of the PA program. "We want our program to be a model of excellence and to promote the physician assistant profession in the state and nationally."

Training physician assistants will help meet the needs of the ever-changing health care landscape, said Dr. Menezes. "The goal is to develop and implement a program that fulfills our mission of promoting high-quality, accessible patient-centered health care, through excellence in education, scholarship and clinical service."

One stated goal of the UNC PA program is to provide educational and training opportunities for non-traditional students, with

attention to those who have served in medical military settings, such as Special Forces medics, for careers in medically underserved areas. "This will provide our veterans with the opportunity to transition into civilian life and use their unique skills to continue with careers in medicine," said Dr. Menezes.

The PA program began as a partnership with Blue Cross and Blue Shield of North Carolina, which made a \$1.2 million commitment to help the University launch the program. The first class of students is expected to matriculate in the fall of 2015, pending accreditation by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA), and approval from the UNC Board of Governors.

WHAT IS ALLIED HEALTH?

The PA program is one of many in the Department of Allied Health Sciences, which is one of the most complex—and, possibly, least understood—departments at the medical school.

Allied health refers to a number of health professions outside of physicians and nurses and encompasses as many as 100 occupational titles. Approximately 5 to 6 million allied health professionals are employed in the United States, comprising 60 percent of the health care workforce. Along with preparing health care practitioners, schools of allied health generate and disseminate research in allied health disciplines, promote interdisciplinary communication and collaboration, and increase the efficient use of resources by a variety of health care providers in order to improve health care.

“The Department of Allied Health Sciences is a very strong department and has contributed to the UNC Health Care and School of Medicine objectives, as well as to serving the people of North Carolina.”

—Stephen R. Hooper, PhD, chair and associate dean for Allied Health Sciences

At UNC, the DAHS was established in 1970, by then-dean Christopher Fordham, as the Department of Medical Allied Health Professions. Prior to that, allied health personnel training was conducted by the staff of individual clinical units within North Carolina Memorial Hospital.

Today, the department includes six divisions: clinical laboratory science, occupational science and occupational therapy, physical therapy, radiologic science, rehabilitation counseling and psychology, and speech and hearing sciences. In addition, the DAHS houses the Center for Literacy and Disability Studies, Center for Human Movement Science, Program for Early Autism Research, Leadership & Service (PEARLS), Neurodiagnostics and Sleep Sciences Program, UNC Hearing and Communication Center, and University Physical Therapy.

Last fall, Stephen R. Hooper, PhD, took over the reigns as chair and associate dean of the Department of Allied Health Sciences following the retirement of Lee McLean, PhD, who led the department for 13 years.

“I spent 26 wonderful years working at the Carolina Institute for Developmental Disabilities and Center for Development and Learning,” said Dr. Hooper. “Now I am very much looking forward to this new role, learning about the department, working with faculty and students, furthering our mission, and keeping our program one of the top in the country.”

To say that the DAHS is complex is an understatement. It now includes more than 425 students and approximately 80 faculty members, offering bachelor’s, master’s and doctoral programs. With such a diverse department, it is understandable that many people are not familiar with it.

“In some respects, the department might not be well understood because each division shines by its own strengths,” said Dr. Hooper. For example, he said, the Physical Therapy and Speech and Hearing Sciences programs are well recognized, but many people do not know the programs are housed within the DAHS. “The achievements of each of these divisions have allowed them to supersede the known dimensions of the department. I see it as a strength that the Department of Allied Health Sciences has evolved over time, and, at the same time, it remains a challenge for the department to develop a singular voice for allied health professionals.”

The department also offers a number of unique programs, such as the Clinical Laboratory Science, Radiologic Sciences, and Neurodiagnostics

and Sleep Sciences programs, which offer undergraduate and graduate studies. Dr. Hooper noted, “Graduates from these programs have extraordinarily high rates of employment, with many staying within the state of North Carolina. This is important as these programs contribute to strengthening the health care workforce across the state and increasing access to care for North Carolina residents. We are proud to be making this contribution to the state.”

The DAHS is also home to an interdisciplinary program in autism spectrum disorders. This evidence-based program relies on various programs within the department to train people in autism and evidence-based practice, allowing the department to partner with a number of strong programs on campus. This is the kind of interdisciplinary activity Dr. Hooper said is instrumental in developing the next leaders of allied health. “Because of the interdisciplinary nature of the DAHS, we really are the department of the future.”

WHAT LIES AHEAD

Today, both research and clinical components of the DAHS are robust. There are many innovative research activities occurring in the DAHS, and Dr. Hooper plans to continue the efforts made in these areas and is committed to working with faculty to find ongoing resources to support these developments.

“We are rather a unique program because there is such a need in the state and across the country for trained professionals in allied health. We are moving forward and, perhaps, leading the nation with this type of educational program and training.”

Dr. Hooper also plans to examine how to expand clinical services in the community and hospital setting, which will provide not only additional opportunities for faculty and students but also will further the availability of quality health care to citizens in all 100 counties of North Carolina. “Our partnership with the North Carolina Area Health Education Centers (AHEC), will be critical in this regard, and we look forward to working collaboratively with the leadership of AHEC to coordinate learning opportunities across the state and to increase the state’s infrastructure for allied health care professionals.

“The department today is strong, its academic mission exceptional, and the divisions and programs within the department are all very highly respected and nationally ranked,” said Dr. Hooper. “We are attracting the best students and providing the best-trained professionals, and we will continue to meet the changing health care needs into the future. Our evolving Physician Assistants program will be a natural fit within this broader mission.”

Community Benefit Report 2013

UNC Health Care fulfills its mission to care for the people of North Carolina in a number of ways. The excellent patient care and groundbreaking medical research throughout the expanding health care system are well known. Perhaps less known is the community outreach accomplished statewide by working with area schools and community organizations.



The UNC Volunteer Association hosts an annual Health Careers Symposium, which gives nearly 200 high school students the opportunity to learn first-hand what it takes to prepare for a career in health care and to work in a clinical setting. The event is part of the Commitment to Communities program at UNC Health Care, which was established in 2009 to expand outreach into the community, both locally and statewide. The goal of the program is to provide North Carolinians with the information and tools needed to maintain and improve their health and well-being, and to work with schools to educate and attract young people to the health care industry.

The Health Careers Symposium highlights many health career paths available to students as they prepare to enter college.

This year's Symposium focused on Family Medicine and the No. 1 ranking the UNC School of Medicine received from *U.S. News & World Report* for its Primary Care program. The event included a panel discussion, question and answer sessions between students and medical professionals, hospital tours, and patient simulations that allowed students to learn and practice patient care using the same methods doctors use.

Rachel Orstad, lead volunteer and coordinator of the Symposium, wanted students to leave the event with a better understanding of what one needs to achieve a successful career in the health care industry. She also hoped to impress upon the students that hospitals encompass more than just direct patient care.

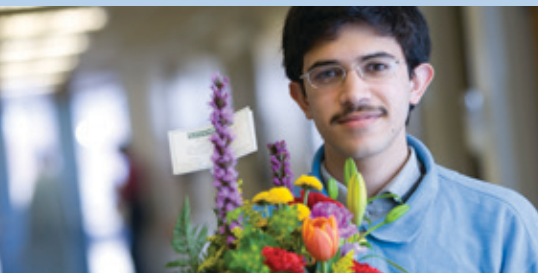
38,000

number of miles walked
by UNC Mallwalkers at The Streets at Southpoint



10,000

school supplies collected
through the Stuff the Bus campaign



\$70,000

in scholarships presented
by the UNC Volunteer Association

\$13.1 million

provided in Pharmacy Assistance Program benefits

“We are able to give students a rounded education and emphasize to them that there is much more to health care than just doctors and nurses,” said Orstad. “For example, we’ve been able to give them insights into the administrative side of health care. For those students interested in business, we help them relate to the hospital as just that: an actual business.”

A DAY IN THE LIFE

The day began with presentations from second- and third-year residents and discussions from a health care career panel. This year’s panel included six professionals: a nurse practitioner, a nurse manager, a nursing school admissions coordinator, a recent nursing graduate, a respiratory therapist and a pharmacist. Students learned how they could prepare now, while in high school, for collegiate medical programs. They gained insight into what to expect in a nursing school setting, the average salaries of medical professionals, the roles in each different area of the industry, and why each of the panelists chose their individual career path.

“We wanted to encourage the students to look toward the health care industry as a field of interest,” said Cathy Gage, MHA, RN-BC, professional development coordinator for Nursing Practice and Professional Development at UNC Health Care. “Our panelists were able to inform them on the health care opportunities available today and the many different routes to become successful health care professionals.”

Following the panel discussion, students toured eight hospital departments and met with staff members for patient simulation exercises using the same equipment on which doctors practice.

“I wanted students to leave the event having enjoyed all of the same things I’ve learned from working with the Symposium over the past decade,” Orstad said. “The kids visibly enjoyed the chance to act as real, certified doctors, and I really think we were able to show them why the medical field should be one to consider in their futures.”



Shane Rogers, director of patient relations and interpreter services at UNC Health Care, left, and Juan Reyes-Alonso, CMI-Spanish, interpreter services system manager at UNC Health Care

Technology Helps Overcome Language Barrier

For patients at UNC Hospitals who need the assistance of an interpreter, a multi-lingual representative is called to ensure they understand their medical care. As UNC Health Care expands its services into the community, we are using technology to facilitate communication with the Limited English Proficiency (LEP) community. We began testing the use of our interpreter robot “Double” in the fall of 2013. “Double” allows a qualified medical interpreter stationed at UNC Hospitals to communicate and interact with patients being served at an off-campus location.

2,297

volunteers served

131,324

hours at UNC Hospitals

ranked
#1 Medical
School
for Primary Care
by U.S. News & World Report
“America’s Best Graduate Schools”

300

Employee Ambassadors volunteered more than

2,000

hours with local charities

555

patients educated by the Baby-Friendly Initiative
at the Women’s Resource Center

\$750,000

to Piedmont Health
to improve access to care



Letter of Transmittal

DECEMBER 31, 2013

To the Governor, the State Auditor, members of the General Assembly, members of the UNC Board of Governors, UNC Chapel Hill Board of Trustees, members of the UNC Health Care System Board of Directors, supporters of the University of North Carolina Health Care System, and William L. Roper, CEO.

INTRODUCTION

This Annual Report includes a compilation of the operating results and financial position of the University of North Carolina Health Care System (UNC Health Care) as established by N.C.G.S. 116-37. The financial reports as presented represent a summary of data generated by the various entities under the control of the Board of Directors of UNC Health Care.

The University of North Carolina Hospitals (UNC Hospitals), Rex Healthcare, Inc. (Rex), Chatham Hospital, Inc. (Chatham), High Point Regional Health (High Point), Caldwell Memorial (Caldwell) and UNC Physicians Network (UNCPN) prepare and publish their own separate audit reports on an annual basis. University of North Carolina Physicians & Associates (UNC P&A), the clinical patient care programs of the University of North Carolina School of Medicine, is included in the audit report for The University of North Carolina at Chapel Hill (UNC-CH). UNC P&A changed its name on Jan. 1, 2013, to University of North Carolina Faculty Physicians (UNCFP) to better identify with the School of Medicine. Additional information regarding the organization structure can be found in the Notes to Financials section of the Annual Report.

The Annual Report is compiled to provide useful information about the entity's operations and programs and to ensure its accountability to the citizens of North Carolina. While UNC Health Care's management believes this information to be accurate, it should be noted that these documents are unaudited and not intended to be used for any financial decisions.

The Financials and Statistics section presents Management's Discussion and Analysis and pro-forma financial statements for UNC Health Care and UNCFP. This section includes selected statistical and financial ratio information. Management's Discussion and Analysis provides a review of the financial operations and the Notes to Financials section provides additional explanations for the reader.

FINANCIAL INFORMATION

Internal Control Structure

UNC Health Care's management establishes and maintains an internal control structure to achieve the objectives of effective and efficient operations, reliable financial reporting, and compliance with applicable laws and regulations. Management applies the internal control standards to meet each of the internal control objectives and to assess internal control effectiveness. When evaluating the effectiveness of internal control over financial reporting and compliance with financial-related laws and regulations, management follows the assessment process to assure to the State of North Carolina and the public that UNC Health Care is committed to safeguarding its assets and is providing reliable financial information.

One objective of an internal control structure is to provide management with reasonable, although not absolute, assurance that assets are safeguarded against loss from unauthorized use or disposition. Another objective is to ensure that transactions are executed in accordance with appropriate authorization and recorded properly in the financial records to permit the preparation of financial statements in accordance with generally accepted accounting principles. Annually, management provides assurances on internal control in its *Performance and Accountability Report*, including a separate assurance on internal control over financial reporting along with a report on identified material weaknesses and corrective actions.

As a recipient of federal and state funds, UNC Health Care is responsible for ensuring compliance with all applicable laws and regulations. A combination of state and UNC Health Care policies and procedures, integrated with a system of internal controls, provides for this compliance. The accounts and operations of UNC Hospitals and UNCFP (as a part of UNC-CH) are subject to an annual examination by the Office of the State Auditor. Rex, Chatham, High Point, Caldwell and UNCPN are audited annually by independent third-party CPA firms. All seven entities are an integral part of the State's reporting entity represented in the State's *Comprehensive Annual Financial Report* and the State's *Single Audit Report*. The audit procedures are conducted in accordance with auditing standards generally accepted in the United States of America and *Government Auditing Standards* issued by the Comptroller General of the United States.

Budgetary Controls

On an annual basis, UNC Health Care's Board of Directors approves budgets for UNC Hospitals, UNCFP, Rex, Chatham, High Point, Caldwell and UNCPN. The budget for UNCFP is also subject to approval by UNC-CH. Each entity of UNC Health Care produces monthly reports that compare budget and actual operating results. Department Heads are expected to review the reports and identify significant variances from their budgets. If necessary, action plans are implemented that will improve negative variances. In addition to the monthly reports, an encumbrance system is maintained by UNC Hospitals and UNCFP to track open purchase orders and commitments made to vendors.

N.C.G.S. 116-37 granted UNC Health Care flexibility for management of UNC Hospitals in regard to its policies for personnel and salary management; purchasing of goods, services and property; and property construction. On an annual basis, UNC Health Care submits a report on its activity under this flexibility. The report is sent to the Educational Planning, Policies, and Programs Committee of the UNC Board of Governors and to the Joint Legislative Commission on Governmental Operations on or before Sept. 30 each year.

UNC Health Care is subject to the provisions of the Executive Budget Act, except for trust funds identified in N.C.G.S. 116-36.1 and 116-37.2. These two statutes primarily apply to the receipts generated by patient billings and other revenues from the operations of UNC Hospitals and UNCFP. UNC Hospitals submits monthly reports to the Office of State Budget and Management that reflect its overall operations. UNC Health Care receives no appropriation from the State. In the past, appropriated funds from the General Fund covered a portion of operating expenses, including the portion of expenses attributable to the cost of providing (i) care to indigent patients and (ii) graduate medical education.

Debt Administration

During the past fiscal year, Rex issued a note payable for \$1.9 million. UNC Health Care's other entities did not enter into new debt-financing arrangements. UNC Hospitals issues debt through the UNC Board of Governors. Rex, Chatham and High Point issue debt through the North Carolina Medical Care Commission.

Standard & Poor's and Moody's ratings services classify UNC Hospitals' bonds as AA and Aa3 respectively. Standard & Poor's, Moody's and Fitch classify Rex's bonds as A+/A1. Standard & Poor's classify Chatham's bonds as A.

Cash and Investment Management

UNC Health Care continues to work with the Office of the State Treasurer and the University of North Carolina Management Company (UNCMC) to maximize the investment earnings for UNC Hospitals based on changes in the General Statutes that were made during the 2005, 2008 and 2011 sessions of the General Assembly. In addition, UNC-CH allowed UNC P&A (now UNCFP) to invest a portion of their funds in an intermediate fund beginning in fiscal year 2008. Investment earnings subsidize operating income and enable UNC Health Care to provide more services to the citizens of the State of North Carolina. The cash management policy includes all areas of receipts and disbursements so that investment earnings are maximized and vendor relations are maintained.


Risk Management

Exposures to loss are handled by a combination of methods, including participation in state-administered insurance programs, purchase of commercial insurance and self-retention of certain risks. The key to managing risk is to ensure that programs are in place that educate and guide employees to the best practices for our industry. We have a responsibility to safeguard our patients so that no additional harm comes to them while under our care. We are similarly committed to ensure a safe workplace for our employees.

In addition to the typical litigation risks with which we are faced, we have to recognize the risk and rewards associated with the health care industry. Continual evaluation of existing programs and new service development is the only way to maintain or increase our competitive advantage.

ACKNOWLEDGEMENTS

Preparation for this Annual Report in a timely manner would not have been possible without the coordinated efforts of the various financial staffs within UNC Health Care, with special assistance from the CEO's office and the Public Affairs & Marketing office.

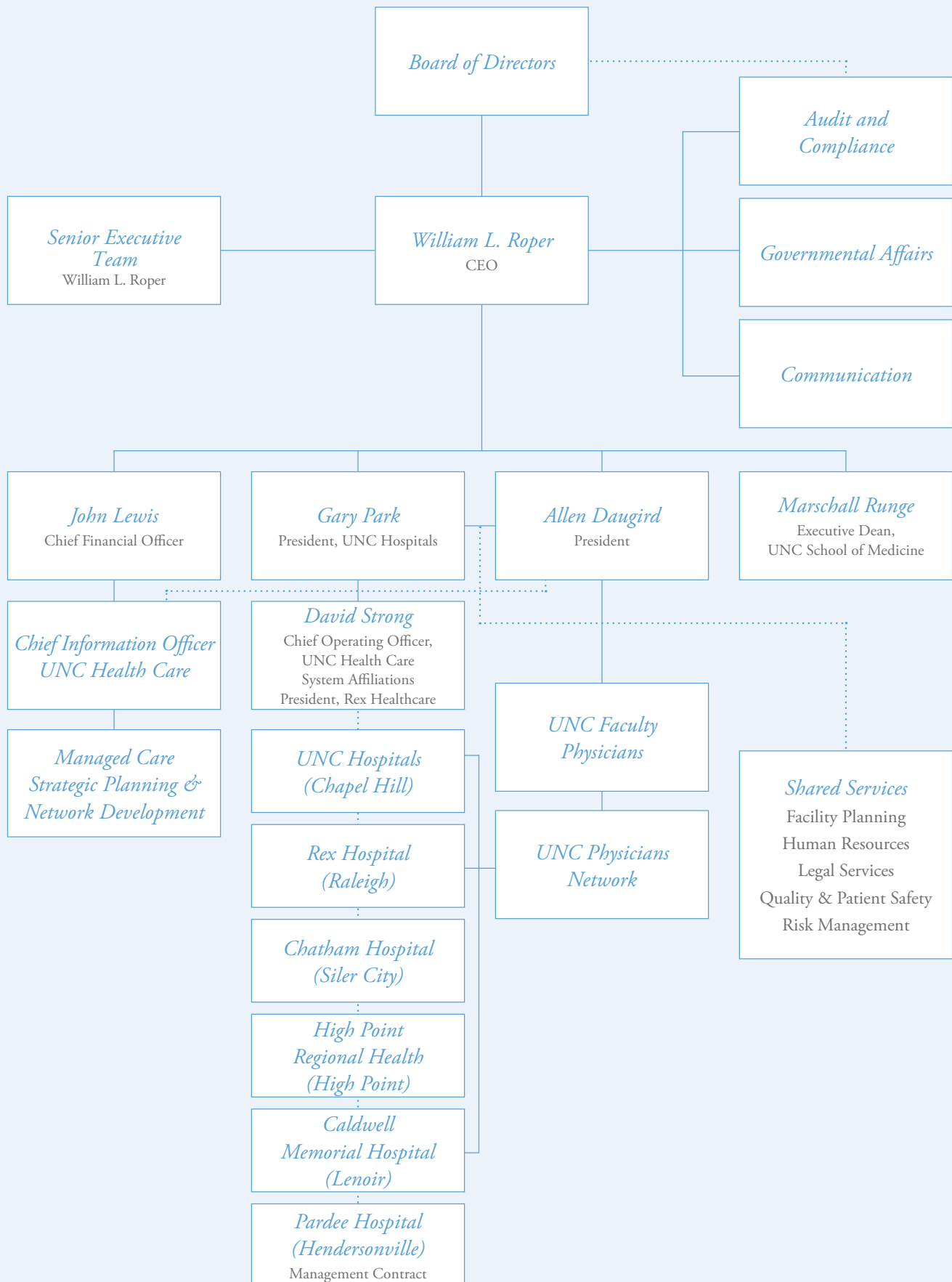


John P. Lewis

Chief Financial Officer

The University of North Carolina Health Care System

UNC Health Care System Reporting Structure



UNC Health Care System Board of Directors

NOVEMBER 2013–OCTOBER 2014

Timothy Burnett

(Chair)
President, Bessemer Improvement Company
Greensboro, NC

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(Vice Chair)
CEO, Medical Mutual Insurance Company of
North Carolina
Raleigh, NC

Anne H. Bernhardt

Vice Chair, Bernhardt Furniture Company
Lenoir, NC

William H. Cameron

President, Cameron Management, Inc.
Wilmington, NC

Susan B. Culp

Past Chair, High Point Regional Health System
High Point, NC

Allen J. Daugird, MD, MBA

President, UNC Faculty Physicians
President, UNC Physicians Network
Chapel Hill, NC

The Reverend Lisa G. Fischbeck

Vicar, The Episcopal Church of the Advocate
Chapel Hill, NC

Carol Folt, PhD

Chancellor, The University of North Carolina
at Chapel Hill
Chapel Hill, NC

Ernest J. Goodson, DDS

Orthodontist
Fayetteville, NC

M. Andrew Greganti, MD

Vice Chair, Department of Medicine
Chapel Hill, NC

Barbara Jessie-Black

Executive Director, PTA Thrift Shop, Inc.
Carrboro, NC

William G. Lapsley

President and Principal Engineer, William G.
Lapsley & Associates, P.A.
Hendersonville, NC

John W. Lassiter

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Charlotte, NC

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Gary Park

President, UNC Hospitals
Chapel Hill, NC

Roger Perry

President, East-West Partners
Chapel Hill, NC

William L. Roper, MD, MPH

Dean, UNC School of Medicine
Vice Chancellor for Medical Affairs
CEO, UNC Health Care System
Chapel Hill, NC

Thomas W. Ross

President, The University of North Carolina
Chapel Hill, NC

Marschall Runge, MD, PhD

Executive Dean, UNC School of Medicine
Chair, Department of Medicine
Director, NC TraCS
Chapel Hill, NC

Kevin Seitz

Interim Vice Chancellor, Finance
and Administration
Chapel Hill, NC

James H. Speed Jr.

President and CEO, North Carolina Mutual Life
Insurance Company
Durham, NC

Greg Wessling

Business Advisor, A&G Associates and
Partners, LLC
Davidson, NC

D. Jordan Whichard III

Retired Publisher and CEO, Cox North Carolina
Publications, Inc.
Private Investor
Greenville, NC

Edward Willingham

President, First Citizens Bank
Raleigh, NC

Management's Discussion and Analysis

INTRODUCTION

Management's Discussion and Analysis provides an overview of the financial position and activities of the University of North Carolina Health Care System (UNC Health Care) for the fiscal years ending June 30, 2013, and June 30, 2012. The financial statements included for UNC Health Care—Statement of Net Position; Statement of Revenues, Expenses, and Changes in Net Position; and Statement of Cash Flows—are labeled “*pro forma*” to demonstrate that they are an aggregation of assets and liabilities and results of financial activities and not the result of an overall audit of UNC Health Care by an independent auditor and, as a result, should not be relied on as such.

UNC Health Care was established Nov. 1, 1998, by N.C.G.S. 116-37. The original legislation included only the University of North Carolina Hospitals (UNC Hospitals) and the clinical patient care programs of The University of North Carolina at Chapel Hill (UNC-CH). UNC Health Care is governed by a Board of Directors and is administered as an affiliated enterprise of The University of North Carolina. UNC Health Care and UNC-CH are sister entities. Rex Healthcare, Inc. (Rex), Chatham Hospital, Inc. (Chatham), High Point Regional Health (High Point), Caldwell Memorial (Caldwell) and UNC Physicians Network (UNCPN) have been added to the organization since its inception. As of Jan. 1, 2013, the clinical patient care programs of the University of North Carolina School of Medicine (School of Medicine) changed its name from University of North Carolina Physicians & Associates (UNC P&A) to University of North Carolina Faculty Physicians (UNCFP) to better identify the relationship with the School of Medicine.

On March 31, 2013, UNC Health Care became the sole corporate member of High Point Regional Health (High Point), a North Carolina not-for-profit corporation organized to own and operate a 351-bed general acute care hospital facility located in High Point, N.C., to promote and advance charitable, educational and scientific purposes, and to provide and support health care services.

On May 1, 2013, UNC Health Care became the sole corporate member of Caldwell Memorial (Caldwell), a private, not-for-profit community hospital in Lenoir, N.C. Caldwell is a 110-bed acute care hospital with a provider network of more than fifty primary and specialty care physicians and advanced practice professionals.

As illustrated in the Reporting Structure on page 23, UNC Health Care owns and/or controls the net assets and financial operations of UNC Hospitals, Rex, Chatham, High Point, Caldwell and UNCPN. UNC-CH owns and controls the net assets and financial operations of UNCFP. The UNC Health Care Board of Directors governs and oversees physician credentialing, quality and patient safety, and resident training and acts to advise and review the financial activities of UNCFP. Final direct control of the monetary operations of UNCFP remains within UNC-CH. The physicians who provide patient care at UNC Hospitals and in UNC-CH clinics are employees of UNC-CH. Most non-physician employees who assist in providing patient care and the

associated administrative, billing and collection services are employees of UNC Health Care.

For purposes of these financial statements, UNCFP serves as a financial proxy for the “clinical patient care programs of the School of Medicine.” The financial statements for the entities directly controlled by UNC Health Care (UNC Hospitals, Rex, Chatham, High Point, Caldwell and UNCPN) are separately audited on an annual basis and have received unqualified opinions for their prior year reports. The financial activities of UNCFP are included in the financial statements and audit report of UNC-CH. Since an unqualified audit opinion on the aggregation of financial information for these entities cannot be efficiently obtained, we have used the term “*pro forma*” to describe fairly the full financial scope and worth of UNC Health Care.

In the interest of being concise, we have included *pro forma* consolidated financial statements for UNC Health Care, which includes UNC Hospitals, Rex, Chatham, High Point, Caldwell, UNCPN and UNCFP. Since UNCFP's financial activities are not separately disclosed elsewhere, we are also presenting UNCFP's *Statement of Net Position*, and *Statement of Revenues, Expenses, and Changes in Net Position* for the fiscal years ending June 30, 2013, and 2012.

USING THE FINANCIAL STATEMENTS

UNC Health Care's financial statements provide information regarding its financial position and results of operations as of the report date. The *Statement of Net Position*; the *Statement of Revenues, Expenses, and Changes in Net Position*; and the *Statement of Cash Flows* comprise the basic financial statements required by the Governmental Accounting Standards Board (GASB).

In accordance with GASB, the *pro forma* financial statements are presented and follow reporting concepts consistent with those required of a private business enterprise. The financial statement balances reported are presented in a classified format to aid the reader in understanding the nature of the operations. The Notes to Financials section provides information relative to the significant accounting principles applied in the financial statements and further detail concerning the organization and its operations. These disclosures provide information to better understand details, risk and uncertainty associated with the amounts reported and are considered an integral part of the financial statements.

The *pro forma Statement of Net Position* provides information relative to the assets, liabilities and net assets as of the last day of the fiscal year. Assets and liabilities on this Statement are categorized as either current or noncurrent. Current assets are those that are available to pay for expenses in the next fiscal year, and it is anticipated that they will be used to pay for current liabilities. Current liabilities are those payable in the next fiscal year. Management estimates are necessary in some instances to determine current or noncurrent categorization. Overall, the *pro forma Statement of Net Position* provides information relative to the financial strength of the organization and its ability to meet current and long-term obligations.

The *pro forma Statement of Revenues, Expenses, and Changes in Net Position* provides information relative to the results of the organization's operations, non-operating activities and other activities affecting net assets, which occurred during the fiscal year. Non-operating activities include noncapital gifts and grants, investment income (net of investment expenses) and loss realized on the disposition of capital assets. Other activities include change in fair value of investments and gain or loss on affiliate activity. Under GASB, the subsidies from the State of North Carolina in the form of appropriations and bond interest expense are considered non-operating activities; but for these *pro forma* statements, they are presented as operating. Overall, the *pro forma Statement of Revenues, Expenses, and Changes in Net Position* provides information relative to the management of the organization's operations and its ability to maintain its financial stability.

The *pro forma Statement of Cash Flows* provides information relative to the Hospitals' sources and uses of cash for operating activities, noncapital financing activities, capital and related financing activities, and investing activities. The Statement provides a reconciliation of beginning cash balances to ending cash balances and is representative of the activity reported on the *pro forma Statement of Revenues, Expenses, and Changes in Net Position* as adjusted for changes in the beginning and ending balances of noncash accounts on the *pro forma Statement of Net Position*.

The Notes to Financials section provides information relative to the significant accounting principles applied in the financial statements, authority for and associated risk of deposits and investments, information on long-term liabilities, accounts receivable, accounts payable, revenues and expenses, pension plans and other post-employment benefits, insurance against losses, commitments and contingencies, accounting changes, and a discussion of adjustments to prior periods and events subsequent to the enterprise's financial statement period when appropriate. Overall, these disclosures provide information to better understand details, risk and uncertainty associated with the amounts reported and are considered an integral part of the financial statements.

COMPARISON OF TWO-YEAR DATA FOR 2013 TO 2012

Data for 2013 and 2012 are presented in this report and discussed in the following sections. Discussion in the following sections is pertinent to fiscal year 2013 results and changes relative to ending balances in fiscal year 2012.

Analysis of Overall Financial Position and Results of Operations

STATEMENT OF NET POSITION

The statements reflect a successful system, with total assets exceeding \$3.2 billion. Total assets increased by 4.5 percent over the prior year, while net assets increased by 4.7 percent during the year ending June 30, 2012.

Assets increased overall by \$141 million, or 4.5 percent, from fiscal year 2012 to 2013, with much of this growth occurring in noncurrent assets. Asset growth was attributable to positive operations, increases to patient accounts receivable and increases to capital assets. The most significant decrease occurred in receivables, as UNC Health Care was paid for supplemental Medicaid payment programs that had been previously accrued. Beginning in 2012, UNC Hospitals, Rex and Chatham transitioned from being reimbursed through the Medicaid cost report to participating in the Hospital Upper Payment Limit (UPL) program. Additionally, UNC Health Care providers who meet specific eligibility criteria participate in the State's Physician UPL program.

Liabilities increased \$44.3 million, or 4.7 percent, from fiscal year 2012. The largest increases occurred as changes in estimated third-party settlements, primarily due to the establishment of an escrow fund for certified public expenditures (CPEs) received from other public North Carolina hospitals. This transaction is discussed in detail in Note 8. Accounts payable increased due to the timing of payments and the amount of invoices processed during the exercise of capturing all applicable invoices in the correct fiscal year. Accrued salaries increased with FTE growth, salary growth and an increase in the employee incentive accrual.

STATEMENT OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION

UNC Health Care generated an operating margin of 3.8 percent, or \$94.2 million, on net operating revenue of \$2.5 billion. Net operating revenue increased by 8.3 percent, or \$199.5 million, primarily attributable to volume growth, increased payments from negotiated payor contracts and the acquisitions of new affiliates. Operating expenses grew at a 10.5 percent rate, driven by acquisition expenses, the opening of the new facilities and increased operating expenses related to the Epic implementation. Aggressive cost containment efforts continue in non-growth areas. In order to remain financially strong, to reinvest in new facilities and to retain the most highly trained work force, UNC Health Care's goal is to average an annual operating margin of at least 4 percent.

Non-operating performance was positive, attributable to improved investment performance during the year. Net income was \$97.2 million, a 3.9 percent margin.

Discussion of Capital Asset and Long-Term Debt Activity

CAPITAL ASSETS

UNC Health Care continued to improve and modernize its facilities during the past year.

UNC Hospitals expended \$56 million during the year for capital equipment throughout the facilities, \$9 million on software, \$8 million on goodwill, and an additional \$91 million on the acquisition of buildings, infrastructure and renovations. Commitments of \$100 million were outstanding on construction contracts at June 30, 2013.

Rex continued growth seen in prior fiscal years. Capital investments in fiscal year 2013 consisted primarily of costs incurred in connection with the ongoing replacement of the central energy plant for the main campus, a new bed tower, and technology and imaging assets.

Chatham experienced a decrease in capital assets between fiscal years 2012 and 2013. This decrease is primarily related to current year depreciation expense. Prior infrastructure projects like the Meditech

Hospital Information System and the Chatham Medical Park were completed in fiscal year 2012.

LONG-TERM DEBT ACTIVITY

UNC Health Care has no borrowing authority. UNC Hospitals, Rex and Chatham have issued revenue bonds in the past and may issue additional debt in the future should the need arise to finance construction projects, and if the market rates are favorable. UNCFP issues its bonds through UNC-CH. As such, its revenues and assets are a part of the bond covenants of UNC-CH.

UNC Hospitals and Chatham did not enter into new debt-financing arrangements during the past fiscal year. Rex issued a \$1.9 million note payable.

Standard & Poor's and Moody's ratings services classify UNC Hospitals' bonds as AA and Aa3 respectively. Standard & Poor's, Moody's and Fitch classify Rex's bonds as A+/A1. Additional information about debt activity can be found in the Notes to Financials section.

Discussion of Conditions that May Have a Significant Effect on Net Assets or Revenues and Expenses

UNC Health Care derives the vast majority of its operating revenues from patient care services. Because the System provides no revenue-generating services, it is entirely dependent upon the financial wherewithal of the entities within UNC Health Care. In recent years, the largest entities of UNC Health Care experienced strong operating performance. That performance has enabled investments made in support of the clinical, education and research programs of UNCFP and the School of Medicine. These investments have, in turn, yielded positive results as measured by growth in needed services, expansion of the medical school class and increased research funding.

The conditions impacting UNC Health Care's operating entities constitute the greatest risk to the System. The health care sector continues to face tumultuous change. Pressure on health care providers has come in the form of expectations to provide greater value, to have fully interoperable electronic health records, to care for the uninsured, to integrate care for individual patients, and to improve wellness across populations.

UNC Health Care has sought to remain a leader in evolving to meet the demands of the changing environment. We are making infrastructure investments to modernize our patient care. The academic medical center in Chapel Hill chronically functions near maximum capacity. Further, many of our facilities, especially in procedural areas, were designed for the care we delivered five decades ago. To address these needs, we will develop our Hillsborough Campus as an extension of the academic campus and an operating room tower on the Chapel Hill campus. These facilities are being designed to optimize efficiency and the patient experience.

We are implementing an integrated medical record across all of our sites of service. UNC Health Care has long operated with electronic medical records. However, the system used at the academic medical center was unique from the system at Chatham, the system at Rex Hospital, or the several systems used in our community physician practices and new affiliates. These systems do not "talk" well with one another, and any form of data transfer between them is limited and cumbersome. Therefore, we established a vision for one patient to have one record everywhere within UNC Health Care. We are currently in the process

of implementing Epic's medical record. This is a pervasive endeavor requiring organizational focus and resources. We will have our first "go-live" in the spring of 2014. The phased rollout will begin in the Triangle, eventually extending to all of our entities statewide.

We are preparing to transition from fee-for-volume to fee-for-value. Traditional payment mechanisms have paid providers for each intervention. As a result, providers are paid more for providing more care, not necessarily for providing better care. UNC Health Care is seeking ways to shift to a new model that shifts risk and accountability to UNC Health Care. We have formed a joint venture with Blue Cross Blue Shield of North Carolina (BCBSNC), Carolina Advanced Health, in which the financial rewards are predicated on improving health outcomes by providing appropriate care. Through early and comprehensive interventions, Carolina Advanced Health has begun to demonstrate that we can reduce overall cost. This is but one example among several that we are pursuing as we embrace the long-term view that to increase the value of our clinical services, we must accept—and be rewarded for accepting—increased accountability and risk.

We are engaging with new partners as the provider community consolidates. Of the more than 100 hospitals in North Carolina, today fewer than 25 remain unaffiliated with larger systems. Nationally, and in North Carolina, the increasing demands on providers, both physician groups and hospitals, has caused many to seek partners in larger systems. Several of these—High Point Regional Health and Caldwell Memorial—have joined UNC Health Care. With our help, these hospitals will be able to provide more of the care needed in local communities. They will be able to access our state-of-the-art information systems (e.g. Epic) that are otherwise unaffordable and they will become more efficient by leveraging UNC Health Care's scale.

We are responding to the State's needs and the needs of underserved populations. UNC Health Care has proudly cared for underserved patients as a safety net provider. In recent years, the cost we incur for those unable to pay for their care has exceeded \$300 million. We also serve North Carolina in other ways, such as providing much of the specialty and hospital care for the Department of Public Safety. We have found multiple cost-saving measures that will preserve taxpayer resources. In early 2013, we also extended our psychiatric services in Wake County. We have opened new inpatient acute psychiatric beds but also operate two levels of step-down care that can be a model for better care that integrates psychiatric services with the patients' other medical needs.

To further the mission of promoting the health of North Carolinians, UNC Health Care contractually agreed to fund the development of a coordinated system of clinical care for Piedmont Health Services, Inc. (PHS), which is a North Carolina nonprofit corporation with six locations serving 14 counties in the Piedmont region. The purpose of this development is to increase access to care for the uninsured. UNC Health Care contributed \$750,000 to PHS for this program during the year ended June 30, 2013.

Successfully managing in the future requires tighter integration of administrative functions across the entities of UNC Health Care, caring for patients in lower-cost delivery settings and comprising sufficient scale to spread the cost of major investments across a broad base. UNC Health Care continues to plan for these changes through a health system-wide planning and implementation process.

Pro Forma Statement of Net Position

For the Years Ended June 30, 2013, and June 30, 2012

	2013	2012*
CURRENT ASSETS		
Cash and Investments	\$345,430,143	\$322,214,912
Patient Accounts Receivable - Net	325,336,794	311,436,568
Inventories	42,531,804	39,135,525
Other Assets and Receivables	188,963,121	247,759,458
Assets Whose Use Is Limited or Restricted	70,369,826	76,605,684
Prepaid Expenses	33,913,735	22,452,499
Total Current Assets	1,006,545,423	1,019,604,646
NONCURRENT ASSETS		
Property, Plant and Equipment - Net	1,227,501,968	1,124,250,960
Assets Whose Use Is Limited or Restricted	971,810,741	913,212,993
Other Assets	75,756,483	83,096,217
Total Noncurrent Assets	2,275,069,192	2,120,560,170
Total Assets	3,281,614,615	3,140,164,816
CURRENT LIABILITIES		
Accounts and Other Payables	229,905,796	182,661,289
Accrued Salaries and Benefits	123,180,149	122,398,736
Estimated Third-Party Settlements	82,628,306	28,767,582
Notes and Bonds Payable	58,627,424	61,646,951
Interest Payable	4,886,394	5,624,618
Other	47,073,621	26,671,788
Total Current Liabilities	546,301,690	427,770,964
NONCURRENT LIABILITIES		
Notes and Bonds Payable	480,154,193	550,373,553
Compensated Absences	89,463,402	93,484,196
Total Noncurrent Liabilities	569,617,595	643,857,749
Total Liabilities	1,115,919,285	1,071,628,713
NET ASSETS	\$2,165,695,330	\$2,068,536,103
TOTAL LIABILITIES AND NET ASSETS	\$3,281,614,615	\$3,140,164,816

*2012 as restated

Pro Forma Statement of Revenues, Expenses, and Changes in Net Position

For the Years Ended June 30, 2013, and June 30, 2012

	2013	2012*
OPERATING REVENUE		
Net Patient Service Revenue	\$2,353,867,062	\$2,187,669,689
State Appropriations	-	18,000,000
Other Operating Revenue	120,169,619	79,868,714
Net Operating Revenue	2,474,036,681	2,285,538,403
OPERATING EXPENSES		
Salaries and Fringe Benefits	1,432,046,273	1,300,356,045
Medical and Surgical Supplies	395,481,375	377,605,808
Contracted Services	237,935,384	202,808,553
Other Supplies and Services	136,151,390	118,017,650
Communications and Utilities	38,482,868	34,859,580
Medical Malpractice Costs	10,707,208	4,878,130
Depreciation	98,067,300	86,816,865
Bond and Other Interest Expense	18,928,831	18,058,571
Medical School Trust Fund (MSTF)	11,992,433	10,413,693
Total Operating Expenses	2,379,793,062	2,153,814,895
OPERATING INCOME (LOSS)	94,243,619	131,723,508
NONOPERATING GAINS (LOSSES)		
Interest and Investment Activity	69,934,529	(12,309,449)
Nonoperating Income (Expense)	(19,240,416)	7,049,642
Grants	(47,778,505)	(12,309,123)
Total Nonoperating Gains (Losses)	2,915,608	(17,568,930)
NET INCOME (LOSS)	\$97,159,227	\$114,154,578

*2012 as restated

Pro Forma Statement of Cash Flows

For the Years Ended June 30, 2013, and June 30, 2012

	2013	2012 *
CASH FLOWS FROM OPERATING ACTIVITIES		
Received from Patients and Third Parties	\$2,393,827,560	\$2,145,522,558
Payments to Employees and Fringe Benefits	(1,435,285,654)	(1,275,577,237)
Payments to Vendors and Suppliers	(764,987,907)	(698,262,710)
Payments for Medical Malpractice	(9,736,677)	(11,444,003)
Other Receipts	107,210,778	26,330,365
Net Cash Provided (Used)	291,028,100	186,568,973
CASH FLOWS FROM NONCAPITAL FINANCING ACTIVITIES		
Health Care System Grants Paid to UNC	(34,528,486)	(6,418,817)
State Appropriations	-	18,000,000
Net Cash Provided (Used)	(34,528,486)	11,581,183
CASH FLOWS FROM CAPITAL FINANCING AND RELATED FINANCING ACTIVITIES		
Proceeds from Issuance of Long-Term Debt	1,899,000	30,072,000
Principal and Arbitrage Paid on Outstanding Debt	(37,108,465)	(51,514,581)
Interest and Fees Paid on Debt	(13,165,098)	(11,161,561)
Capital Grants	-	-
Acquisition and Construction of Capital Assets	(165,688,273)	(100,699,566)
Net Cash Provided (Used)	(214,062,836)	(133,303,708)
CASH FLOWS FROM INVESTING ACTIVITIES		
Investment Income and Other Activity	18,860,892	11,611,060
Purchase and Sale of Investments, Net of Fees	(14,189,324)	(49,876,001)
Investments in and Loans to Affiliated Enterprises - Net	(23,893,115)	(12,154,297)
Net Cash Provided (Used)	(19,221,547)	(50,419,238)
NET INCREASE (DECREASE)	\$23,215,231	\$14,427,210
BEGINNING CASH AND CASH EQUIVALENTS	\$322,214,912	\$307,787,702
ENDING CASH AND CASH EQUIVALENTS	\$345,430,143	\$322,214,912

*2012 as restated

Statement of Net Position (Unaudited)

For the Years Ended June 30, 2013, and June 30, 2012

	2013	2012
CURRENT ASSETS		
Cash and Investments	\$109,286,936	\$114,913,876
Patient Accounts Receivable - Net	35,831,603	30,733,663
Inventories	-	-
Estimated Third-Party Settlements	44,950,304	31,541,163
Other Assets and Receivables	6,501,315	18,497,086
Assets Whose Use Is Limited or Restricted	-	6,935,428
Prepaid Expenses	-	-
Total Current Assets	196,570,158	202,621,216
NONCURRENT ASSETS		
Property, Plant and Equipment - Net	-	1,649,800
Assets Whose Use Is Limited or Restricted	-	-
Other Assets	-	-
Total Noncurrent Assets	-	1,649,800
Total Assets	196,570,158	204,271,016
CURRENT LIABILITIES		
Accounts and Other Payables	24,869,105	22,959,075
Accrued Salaries and Benefits	12,699,342	18,345,518
Estimated Third-Party Settlements	7,289,557	6,944,026
Notes and Bonds Payable	-	1,649,800
Interest Payable	-	-
Other	1,489,949	1,537,733
Total Current Liabilities	46,347,953	51,436,152
NONCURRENT LIABILITIES		
Notes and Bonds Payable	-	-
Compensated Absences	22,155,891	26,688,000
Estimated Third-Party Settlements	-	-
Total Noncurrent Liabilities	22,155,891	26,688,000
Total Liabilities	68,503,844	78,124,152
NET ASSETS	\$128,066,314	\$126,146,864
TOTAL LIABILITIES AND NET ASSETS	\$196,570,158	\$204,271,016

Statement of Revenues, Expenses, and Changes in Net Position (Unaudited)

For the Years Ended June 30, 2013, and June 30, 2012

	2013	2012
OPERATING REVENUE		
Net Patient Service Revenue	\$298,614,149	\$297,297,510
State Appropriations	-	-
Other Operating Revenue	79,466,629	56,738,651
Net Operating Revenue	378,080,778	354,036,161
OPERATING EXPENSES		
Salaries and Fringe Benefits	323,060,954	310,056,600
Medical and Surgical Supplies	14,739,811	13,523,754
Contracted Services	24,430,533	14,505,817
Other Supplies and Services	23,628,007	23,835,411
Communications and Utilities	2,642,048	2,256,667
Medical Malpractice Costs	3,223,094	826,810
Depreciation	-	-
Bond and Other Interest Expense	1,691,292	1,671,762
Medical School Trust Fund (MSTF)	11,992,433	10,413,693
Total Operating Expenses	405,408,172	377,090,514
OPERATING INCOME (LOSS)	(27,327,394)	(23,054,353)
NONOPERATING GAINS (LOSSES)		
Interest and Investment Income	3,361,981	334,847
Nonoperating Income (Expense)	-	-
Gain (Loss) on Investment in Affiliates	-	-
Realized and Unrealized Investment Activity	-	-
Transfers to HCS Enterprise Fund	(20,684,562)	(21,224,718)
Transfers from HCS Enterprise Fund	46,569,425	53,051,414
Total Nonoperating Gains (Losses)	29,246,844	32,161,543
NET INCOME (LOSS)	\$1,919,450	\$9,107,190

Statement of Cash Flows (Unaudited)

For the Years Ended June 30, 2013, and June 30, 2012

	2013	2012
CASH FLOWS FROM OPERATING ACTIVITIES		
Received from Patients and Third Parties	\$280,452,599	\$302,544,621
Payments to Employees and Fringe Benefits	(333,239,239)	(303,951,905)
Payments to Vendors and Suppliers	(63,701,247)	(36,157,941)
Payments for Medical Malpractice	3,835,428	(6,721,237)
Operating Capital Grants	58,565,196	48,490,345
Other Receipts	67,474,196	46,324,958
Net Cash Provided (Used)	13,386,933	50,528,841
CASH FLOWS FROM CAPITAL FINANCING AND RELATED FINANCING ACTIVITIES		
Principal and Arbitrage Paid on Outstanding Debt	-	(1,549,800)
Interest and Fees Paid on Debt	(1,691,292)	(221,962)
Proceeds from Financing Agreements	-	-
Acquisition and Construction of Capital Assets	-	100,000
Net Cash Provided (Used)	(1,691,292)	(1,671,762)
CASH FLOWS FROM INVESTING ACTIVITIES		
Investment Income and Other Activity	3,361,981	334,847
Purchase and Sale of Investments, Net of Fees	-	-
Investments in and Loans to Affiliated Enterprises - Net	(20,684,562)	(21,224,718)
Net Cash Provided (Used)	(17,322,581)	(20,889,871)
NET INCREASE (DECREASE)	\$(5,626,940)	\$27,967,208
BEGINNING CASH AND CASH EQUIVALENTS	\$114,913,876	\$86,946,668
ENDING CASH AND CASH EQUIVALENTS	\$109,286,936	\$114,913,876

Pro Forma Selected Statistics and Ratios

For the Years Ended June 30, 2013, and June 30, 2012

	REX SITES	CHATHAM SITES	HPRH SITES	CALDWELL SITES	UNC SITES	UNCPN SITES	2013 UNC HEALTH CARE TOTAL	2012* UNC HEALTH CARE TOTAL
PATIENT SERVICE STATISTICS								
Patient Days	116,729	3,033	17,160	2,888	250,796		390,606	367,639
Inpatient Discharges	25,486	545	4,075	594	36,989		67,689	64,060
Average Length of Stay	4.1	3.1	4.3	4.9	6.6		5.8	5.7
Inpatient Operating Room Cases	9,351	17	723	213	12,174		22,478	21,265
Outpatient Operating Room Cases	21,277	793	741	726	17,030		40,567	38,318
Emergency Department Visits	57,944	15,823	15,797	4,663	77,736		171,963	145,866
Clinic Visits	106,179	-	55,787	-	964,151	553,542	1,679,659	1,242,634
Births/Deliveries	5,292	-	335	77	3,575		9,279	9,027
FINANCIAL RATIOS								
Operating Margin Percentage							3.81%	6.13%
Operating Margin Percentage (excluding cost report settlements)							3.81%	6.13%
Days in Net Accounts Receivable							50.45	45.88
Days of Cash on Hand (includes investments)							217.34	233.10
Average Payment Period (days)							103.85	73.35
Long-Term Debt to Equity							18.15%	20.70%
Current Debt Service Coverage							2.76	3.61

*2012 as restated

Notes to Financials

NOTE 1 // SIGNIFICANT ACCOUNTING POLICIES

A. ORGANIZATION – The University of North Carolina Health Care System (UNC Health Care) was established Nov. 1, 1998, by N.C.G.S. 116-37. It is governed and administered as an affiliated enterprise of The University of North Carolina system with its stated purpose to provide patient care, facilitate the education of physicians and other health care providers, conduct research collaboratively with the health sciences schools of The University of North Carolina at Chapel Hill (UNC-CH), and render other services designed to promote the health and well-being of the citizens of North Carolina.

The original legislation included the University of North Carolina Hospitals at Chapel Hill (UNC Hospitals) and the clinical patient care programs established or maintained by the School of Medicine of UNC-CH (School of Medicine), including University of North Carolina Physicians & Associates (UNC P&A). As of Jan. 1, 2013, UNC P&A changed its name to University of North Carolina Faculty Physicians (UNCFP) to better identify the relationship with the School of Medicine. UNC Health Care is under the governance of the Board of Directors of UNC Health Care. Rex Healthcare, Inc. (Rex), Chatham Hospital, Inc. (Chatham), High Point Regional Health (High Point), Caldwell Memorial (Caldwell) and UNC Physicians Network (UNCPN) have been added to the organization since its inception.

The University of North Carolina Hospitals – The University of North Carolina Hospitals at Chapel Hill (UNC Hospitals) is the only state-owned teaching hospital in North Carolina. With a licensed base of 830 beds, this facility serves as an acute care teaching hospital for The University of North Carolina at Chapel Hill. UNC Hospitals consists of North Carolina Memorial Hospital, North Carolina Children's Hospital, North Carolina Neurosciences Hospital, North Carolina Women's Hospital and North Carolina Cancer Hospital. As a state agency, UNC Hospitals is required to conform to financial requirements established by various statutory and constitutional provisions. While UNC Hospitals is exempt from both federal and state income taxes, a small portion of its revenue is subject to the unrelated business income tax.

BLENDED COMPONENT UNITS – Although legally separate, Health System Properties, LLC (the LLC), a component unit of UNC Hospitals, is reported as if it were part of the Hospitals.

The LLC was established to purchase, develop and/or lease real property. Because the UNC Health Care System is the sole member manager of the LLC, the elected directors of the LLC are the same members of the UNC Health Care System Board of Directors that directs UNC Hospitals' operations, and as the LLC's primary purpose is to benefit UNC Hospitals, its financial statements have been blended with those of UNC Hospitals.

The University of North Carolina Faculty Physicians – Formerly known as UNC Physicians & Associates, University of North Carolina Faculty Physicians (UNCFP) is the clinical service component of the UNC School of Medicine. At the heart of UNCFP are the approximately 1,100 physicians who provide a full range of specialty and primary care services for patients of UNC Health Care. While the great majority of services are rendered at the inpatient units of UNC Hospitals and the outpatient clinics on the UNC campus, there is a growing range of services provided at clinics in the community. There are 18 clinical departments, two affiliated departments and two administrative units that collectively form UNCFP.

CLINICAL DEPARTMENTS:

Anesthesiology	Orthopaedics
Dermatology	Otolaryngology
Emergency Medicine	Pathology & Laboratory Medicine
Family Medicine	Pediatrics
Medicine	Psychiatry
Neurology	Physical Medicine & Rehabilitation
Neurosurgery	Radiation Oncology
Obstetrics & Gynecology	Radiology
Ophthalmology	Surgery

AFFILIATED DEPARTMENTS:

Allied Health Sciences
Center for Development and Learning

ADMINISTRATIVE UNITS:

Administrative Office (Billing & Collections, Managed Care)
Ambulatory Administration

While UNCFP is affiliated with UNC Health Care, the net assets of UNCFP are held in a UNC-CH trust fund. The operating income and expenses for UNCFP are managed via UNC-CH's accounting infrastructure; and, as such, its operational results are included in the annual audit for UNC-CH.

Rex Healthcare, Inc. – Rex Healthcare, Inc. (Rex) is a not-for-profit corporation and is exempt from federal and North Carolina income taxation as a 501(c)(3) charitable organization. Rex does not conduct active operations but serves as the parent corporation for a multi-entity health care delivery system that was organized to provide a wide range of health care services to the residents of Wake County, N.C., and surrounding counties. UNC Health Care acquired Rex in 2000, and is the sole member of the corporation. The System appoints eight of the 13 seats on Rex's Board of Trustees and reviews and approves Rex's annual operating and capital budgets. The principal corporate entities under the common control of Rex are:

REX HOSPITAL, INC. – Rex Hospital, Inc., is a 433-bed hospital located in Raleigh, N.C., that provides inpatient, outpatient and emergency services primarily to the residents of Wake County, N.C. Rex Hospital also operates Rex Cancer Center, Rex Women's Center, and Rex Rehabilitation and Nursing Care Center of Raleigh on its main campus. Rex Hospital has additional campuses in Cary, Wakefield (in Raleigh), Garner, Holly Springs, Knightdale and Apex. Rex Hospital owns Rex Home Services, Inc., which primarily serves residents of Wake County. Rex also provides radiation oncology services in Johnston County.

REX ENTERPRISES COMPANY, INC. – Rex Enterprises Company, Inc., is a North Carolina for-profit corporation organized to hold investments in various affiliates and to promote the development of real property in support of the mission of Rex. Rex Enterprises Company, Inc., is the sole member of Rex CDP Ventures, LLC, which is a limited liability company organized to own and develop real estate in the Wakefield community of northern Wake County.

REX HEALTHCARE FOUNDATION, INC. – Rex Healthcare Foundation, Inc., is a North Carolina not-for-profit corporation organized to promote the health and welfare of residents in Rex's service area by promoting philanthropic contributions and public support of Rex.

REX HOLDINGS, LLC – Rex Holdings, LLC was formed in 2007 to provide medical services through various affiliations, joint ventures and independent physician

practices. Rex Holdings, LLC is the sole member of Rex Physicians, LLC, which was established in 2009 to employ physicians of specialty practices.

Chatham Hospital, Inc. – Chatham Hospital, Inc., is a private, nonprofit 501(c)(3) corporation that owns and operates a 25-bed critical access facility located in Siler City, N.C. The facility operates 21 acute/swing beds and four intensive care beds, along with a complement of surgical suites, emergency room and ancillary services.

UNC Health Care became the sole member of Chatham Hospital, Inc. on July 1, 2008. The System appoints nine of the 15 members on the Chatham Hospital, Inc. Board and reviews and approves its annual operating and capital budgets.

UNC Physicians Network, LLC – UNCPN is a wholly owned subsidiary of the System, but a private employer, that owns and operates more than 30 community physician practices throughout the Triangle (Raleigh, Durham and Chapel Hill), N.C., area.

UNCPN is a physician-led network structured to meet the needs of the community and community practice physicians by creating a partnership for physicians and UNC Health Care to face the challenging health care environment. UNCPN incorporates legacy community-based practices as well as newly acquired practices.

First Health – UNC HCS, LLC – First Health – UNC HCS, LLC was a joint venture between UNC Health Care and First Health of the Carolinas, Inc., which was created to purchase and operate Sanford Hematology & Oncology (SHO), a clinic located in Sanford, N.C. Each entity had a 50 percent ownership interest in SHO.

UNC Health Care and First Health agreed that the future of the practice would be better served by First Health assuming sole ownership of the practice. On July 1, 2013, UNC Health Care sold its 50% share of the practice, and the LLC was dissolved.

High Point Regional Health, Inc. – High Point Regional Health, Inc. (HPRH) is a North Carolina not-for-profit corporation to own and operate a 351-bed general acute hospital facility located in High Point, N.C., to promote and advance charitable, educational and scientific purposes, and to provide and support health care services.

On March 31, 2013, UNC Health Care became the sole corporate member of HPRH. HPRH is the parent holding company of High Point Regional Health Foundation, High Point Health Care Ventures, Inc., and High Point Regional Health Services, Inc.

HIGH POINT REGIONAL HEALTH FOUNDATION – A North Carolina not-for-profit corporation organized solely for charitable purposes for the promotion of health and wellness to the general public through the support of services and mission of High Point Regional Health.

HIGH POINT HEALTH CARE VENTURES, INC. – A for-profit corporation organized to promote health care and related activities. Its operation consists of a fitness center and laboratory services.

HIGH POINT REGIONAL HEALTH SERVICES, INC. – A not-for-profit corporation organized to conduct health care and related services. Its operations consist of physicians practices, imaging services and partnerships to provide durable medical equipment, various therapies, home health services, and services to the indigent population of Guilford County.

HIGH POINT SURGERY CENTER, GP (HPSC) – A general partnership with Surgery Center Associates of High Point, LLC, owned by 18+ physicians, all of whom are on the HPRH medical staff. HPSC provides access to outpatient surgical services on weekdays, with an overnight stay option.

PREMIER SURGERY CENTER, LLC – An ambulatory surgery center scheduled to open in April 2014.

Caldwell Memorial Hospital – A private, not-for-profit community hospital in Lenoir, N.C. Caldwell is a 110-bed acute care hospital with a provider network of more than 50 primary and specialty care physicians and advanced practice professionals.

UNC Health Care became the sole corporate member of Caldwell on May 1, 2013.

B. BASIS OF PRESENTATION – The accompanying financial statements present all activities under the direction of the UNC Health Care Board of Directors. The financial statements for UNC Health Care are presented as a compilation of the various statements generated by its separate entities. UNC Hospitals, Rex, Chatham and UNCPN issue their own audited financial statements while UNCFP is included as a part of the audited statements for UNC-CH.

In compiling the financial statements for UNC Health Care, significant intercompany transactions and balances between the related parties have been eliminated. In addition, while the general statutes refer to only the clinical operations of the School of Medicine, which are reported through UNCFP, this annual report includes the assets, liabilities and net assets of UNCFP, which are included in the audited financial statements for UNC-CH.

C. BASIS OF ACCOUNTING – The financial statements of the various entities have been prepared using the accrual basis of accounting for UNC Hospitals, Rex, Chatham and UNCPN, and the modified accrual basis of accounting for UNCFP. Under the accrual basis, revenues are recognized when earned; and expenses are recorded when an obligation has been incurred. When preparing the financial statements, management makes estimates and assumptions that affect the reported amounts of assets and liabilities, disclosure of contingent assets and liabilities at the date of the financial statements, and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from the estimates. For UNCFP, their monthly financials are maintained on a cash basis; and then at year-end, adjustments are made to accrue all known material amounts for revenue and expense.

D. CURRENT AND NONCURRENT DESIGNATION – Assets are classified as current when they are expected to be collected within the next 12 months or consumed for a current expense in the case of cash or prepaid items. Liabilities are classified as current if they are due and payable within the next 12 months.

E. REVENUE AND EXPENSE RECOGNITION – Revenues and expenses are classified as operating or non-operating in the accompanying Statements of Revenues, Expenses, and Changes in Net Position. Operating revenues and expenses generally result from providing services and producing and delivering goods in connection with the principal ongoing operations. Operating revenues include activities that have characteristics of exchange transactions, such as charges for inpatient and outpatient services, as well as for external customers who purchase medical services or supplies. Operating expenses are all expense transactions incurred other than those related to capital and noncapital financing or investing activities.

Non-operating revenues include activities that have the characteristics of non-exchange transactions. Revenues from non-exchange transactions “and donations” that represent subsidies or gifts, as well as investment income “and gain (loss) on disposal of capital assets,” are considered non-operating since these are investing, capital or noncapital financing activities.

F. CASH AND CASH EQUIVALENTS – This classification includes petty cash, security deposits, cash on deposit in private bank accounts and deposits held by the State Treasurer in the short-term investment fund (STIF). The STIF account has the general characteristics of a demand deposit account in that participants may deposit and withdraw cash at any time without prior notice or penalty. All highly liquid investments with an original maturity of three months or less, and which are not designated as investments, are considered to be cash equivalents and are recorded at cost, which approximates market.

UNC-CH manages the funds of UNCFP as authorized by the University of North Carolina Board of Governors pursuant to N.C.G.S. 116-36.2 and Section 600.2.4

of the Policy Manual of The University of North Carolina. Special funds and funds received for services rendered by health care professionals pursuant to N.C.G.S 116-36.1(h) are invested in the same manner as the State Treasurer is required to invest. Investments of various funds may be pooled unless prohibited by statute or by terms of the gift or contract. UNC-CH utilizes investment pools to manage investments and distribute investment income. Shares in the temporary pool trade at a fixed value of \$1 per share.

G. INVESTMENTS – This classification includes marketable debt and equity securities with readily determinable fair values, including assets whose use is limited and are measured at fair value.

Investment income or loss (including realized and unrealized gains and losses on investments, interest and dividends) is included in non-operating income (loss). The calculation of realized gains and losses is independent of a calculation of the net change in the fair value of investments.

H. PATIENT ACCOUNTS RECEIVABLE, NET – Net patient accounts receivable consist of unbilled (in-house patients, inpatients discharged but not final billed and outpatients not final billed) and billed amounts. Payment of these charges comes primarily from managed care payors, Medicare, Medicaid and, to a lesser extent, the patient. The amounts recorded in the financial statements are net of indigent care, contractual allowances and allowances for bad debt to determine the net realizable value of the accounts receivable balance.

Reserves for these deductions are recorded based on the historical collection percentage realized for each payor and projections for future collection rates. Flexible payment arrangements with selected payors have been established to optimize collection of past-due accounts, and any amounts payable beyond one year are classified as noncurrent assets.

I. ESTIMATED THIRD-PARTY SETTLEMENTS – Estimated third-party amounts represent settlements with Medicare, TRICARE and Medicaid programs that may result in a receivable or a payable. Reimbursement for cost-based items is paid at a tentative interim rate with final settlement determined after submission of annual cost reports and audits thereof by fiscal intermediaries. Final settlements under the Medicare and Medicaid programs are based on regulations established by the respective programs and as interpreted by fiscal intermediaries. The classification of patients under the Medicare and Medicaid programs as well as the appropriateness of their admission is subject to review. Several years of cost reports are currently under review. Beginning in 2012, UNC Health Care's physician and hospital entities receive supplemental reimbursement for Medicaid via the Upper Payment Limit methodology.

J. INVENTORIES – Inventories consist of medical and surgical supplies, pharmaceuticals, prosthetics, and other supplies that are used to provide patient care by service departments. Inventories are stated at the lower of cost or market on the FIFO (first-in, first-out) basis.

K. OTHER ASSETS AND RECEIVABLES – Other assets and receivables relate to items such as sales tax refunds due from the North Carolina Department of Revenue, amounts due from affiliates and other state agencies, and billings to outside companies for ancillary testing.

L. ASSETS WHOSE USE IS LIMITED OR RESTRICTED – Current assets whose use is limited or restricted include the debt service funds established with the trustee in accordance with the bond indenture agreements and donor restrictions. The debt service funds will be used to pay bond interest and principal as it becomes due.

Noncurrent assets whose use is limited or restricted include the bond proceeds for construction projects, the funds required by the bond indenture agreements, funds in the maintenance reserve fund that will be used to acquire or construct future property, plant or equipment and the money on deposit with the Liability Insurance Trust Fund.

M. PREPAID EXPENSES – Prepaid expenses represent current year expenditures for services that extend beyond the current reporting cycle. Payments include insurance premiums, maintenance contracts and lease arrangements.

N. PROPERTY, PLANT AND EQUIPMENT – Property, plant and equipment are stated at cost at date of acquisition or fair value at date of donation in the case of gifts. The value of assets constructed includes all material direct and indirect construction costs. Interest costs incurred during the period of construction are capitalized. Only assets having a cost or fair value of at least \$5,000 and an estimated useful life of three years or more are capitalized.

Assets under capital lease are stated at the present value of the minimum lease payments at the inception of the lease.

Depreciation is computed using the straight-line method over the estimated useful lives of the assets, generally three to 20 years for equipment, 10 to 40 years for buildings and fixed equipment, and five to 25 years for general infrastructure and building improvements. Assets under capital leases and leasehold improvements are depreciated over the related lease term, generally periods ranging from five to seven years.

O. OTHER NONCURRENT ASSETS – Other noncurrent assets include amounts for long-term payment arrangements for patient accounts receivable, bond issuance costs-net of amortization and investments in affiliates.

P. ACCOUNTS AND OTHER PAYABLES – Accounts and other payables represent the accrual of expenses for goods and services that have been received as of the end of the year but have not been paid.

Q. ACCRUED SALARIES AND BENEFITS – Accrued salaries and benefits represent the accrual of salaries and associated benefits earned as of the end of the year but which have not been paid.

R. NOTES AND BONDS PAYABLE – Notes and bonds payable represent debt issued for the construction of buildings and the acquisition of equipment. The current amount is the portion of bonds due within one year, and the balance is reflected as noncurrent.

The bonds carry interest rates ranging from 0.12 percent to 10.1 percent. The various bond series have fixed, variable or synthetic rates with final maturity in fiscal year 2034. Bonds payable are reported net of unamortized discount, premium and deferred loss on refundings. Amortization of these amounts is done using either the effective interest method or the straight-line method. The notes payable carry various interest rates ranging from 1.64 percent to 11.02 percent with a final maturity in fiscal year 2029.

Information for High Point and Caldwell is unaudited, and is based on estimates from prior year audited statements and management.

S. INTEREST PAYABLE – Interest payable represents accrued interest at the end of the year that has not yet been paid.

T. OTHER CURRENT LIABILITIES – Other current liabilities represent funds held for others and amounts due to patients or third parties for credit balances.

U. COMPENSATED ABSENCES – Compensated absences represent the liability for employees with accumulated leave balances earned through various leave programs. These amounts would be payable if an employee terminated employment. Employees earn leave at varying rates depending upon their years of service and the leave plan in which they participate.

V. NET ASSETS – Net assets represent the difference between assets and liabilities. Due to the complexities of consolidating these entities, only a combined number is shown for net assets.

Normally, under general accepted accounting principles, the net asset category would be further categorized as the amounts (1) Invested in Capital Assets, Net of Related Debt, (2) Restricted Net Assets – Expendable and (3) Unrestricted Net Assets.

W. NET PATIENT SERVICE REVENUE – Patient service revenue is recorded at established rates when services are provided with contractual adjustments, estimated bad debt expenses and services qualifying as charity care deducted to arrive at net patient service revenue. Contractual adjustments arise under reimbursement agreements with Medicare, Medicaid, certain insurance carriers, health maintenance organizations and preferred provider organizations, which provide for payments that are generally less than established billing rates. The difference between established rates and the estimated amount collectable is recognized as revenue deductions on an accrual basis.

Charity care represents health care services that were provided free of charge or at rates that are less than the established rates to individuals who meet the criteria of UNC Health Care's charity care and uninsured policy. For UNC Hospitals and UNCFP, uninsured patients receive a 35 percent discount for medically necessary treatment. Charity care provided is not considered to be revenue, since no effort is made to collect accounts that fall under this policy.

Medicare reimburses for inpatient acute care services under the provisions of the Prospective Payment System (PPS). Under PPS, payment is made at predetermined rates for treating various diagnoses and performing procedures that have been grouped into defined diagnostic-related groups (DRGs) applicable to each patient discharge rather than on the basis of the Hospitals' allowable charges. Psychiatric and rehabilitation inpatient services are reimbursed under separate programs.

A prospective payment system for outpatient services was implemented Aug. 1, 2000, and is based on ambulatory payment classifications. It applies to most hospital outpatient services other than ambulance, rehabilitation services, clinical diagnostic laboratory services, dialysis for end-stage renal disease, non-implantable durable medical equipment, prosthetic devices and orthotics.

Medicaid reimburses inpatient services on an interim basis under a Prospective Payment System. Medicaid uses the Medicare DRG system with some modifications. Medicaid reimburses outpatient services on an interim basis at an agreed upon percent of charges but is settled based on documented cost for all services except hearing aids, durable medical equipment (DME), outpatient pharmacy and home health.

Hospital payments for Medicare and Medicaid services are made based on a tentative reimbursement rate with final settlement determined after submission of the appropriate cost reports by the entities within UNC Health Care. Medicaid reimburses physician services at a rate of ninety-five percent (95 percent) of allowable Medicare rates. UNCFP is also reimbursed on a cost-basis, receiving the federally reimbursed portion of costs of providing care to Medicaid patients not covered by fee-for-service reimbursement.

X. MEDICAL AND SURGICAL SUPPLIES – Medical and surgical supplies represent the items used to provide patient care. This includes instruments, special medical devices and pharmaceuticals.

Y. MEDICAL MALPRACTICE COSTS – Medical malpractice costs represent the actuarially determined contributions required for self-insured funding or commercial premiums for third-party coverage. The coverage is intended to include both reported claims and claims that have been incurred but not yet reported.

Z. MEDICAL SCHOOL TRUST FUND – Medical School Trust Fund (MSTF) expenses represent an assessment of 4.6 percent of net patient service revenue. The MSTF funds are at the Dean's discretion for the support of projects such as program development and recruitment incentives for new department chairs.

AA. DONATED SERVICES – No amounts have been included for donated services since no objective basis is available to measure the value of such services. However, a substantial number of volunteers donated significant amounts of their time to the operations of UNC Health Care.

BB. CONCENTRATION OF CREDIT RISK – UNC Health Care provides services to a relatively compact area surrounding the Research Triangle Park, without collateral or other proof of ability to pay. Concentration of credit risk with respect to patient accounts receivable are limited due to large numbers of patients served and formalized agreements with third-party payors. Significant accounts receivable are dependent upon the performance of certain governmental programs, primarily Medicare and North Carolina Medicaid for their collectability. Management does not believe there are significant credit risks associated with these governmental programs.

NOTE 2 // ESTIMATED THIRD-PARTY SETTLEMENTS

For Medicare and Medicaid, reported amounts reflect the net difference between the filed cost report settlements and amounts reserved for possible future audit findings. TRICARE/CHAMPUS is a federal insurance program for eligible active duty and retired military personnel and their dependents. TRICARE/CHAMPUS makes payments on an interim basis. Upon completion of the Medicare Cost Report, TRICARE will reimburse certain portions of direct medical and paramedical education and capital costs from the Medicare Cost Report.

NOTE 3 // CAPITAL ASSETS

A summary of capital assets as of June 30 was:

	FY2013	FY2012
Land and Improvements	98,259,323	96,369,752
Buildings and Improvements	917,597,105	889,096,731
Equipment	844,282,141	749,130,063
Goodwill	7,704,529	0
Construction in Progress	143,304,281	96,280,770
Gross PP&E	2,011,147,379	1,830,877,316
Accumulated Depreciation	(967,899,262)	(882,523,384)
Net PP&E	\$1,043,248,117	\$948,353,932

NOTE 4 // LONG-TERM DEBT

A summary of outstanding bond debt and related issuance costs as of June 30 was:

	FY2013	FY2012
Chatham Series 2007 Bonds	27,265,000	28,000,000
UNCFP Series Bonds	0	1,649,800
Rex Series 1998 Bonds	0	0
Rex Series 2010A Bonds	115,200,000	119,847,000
UNCH Series 1999 Bonds	0	0
UNC Hospitals Series 2001 Bonds	95,200,000	96,800,000
UNC Hospitals Series 2003 Bonds	92,905,000	93,490,000
UNC Hospitals Series 2005 Bonds	7,960,000	11,660,000
UNC Hospitals Series 2009 Bonds	34,800,000	37,295,000
UNC Hospitals Series 2010 Bonds	45,220,000	47,075,000
High Point Regional Series 1997 & 1999 Bonds	39,460,000	
FACE VALUE OF BONDS OUTSTANDING	458,010,000	435,816,800
Deferred Costs - Discount on Issuance	0	0
Deferred Costs - Loss on Refunding	(12,996,644)	(14,194,576)
Deferred Costs - Premium on Issuance	4,744,274	5,403,529
Arbitrage Rebate Payable	225,018	125,010
Hedging Liability	18,480,241	26,832,040
NET VALUE OUTSTANDING	468,462,889	453,982,803
Current Portion of Bonds	51,168,076	17,259,800
Current Portion of Notes	7,459,348	11,784,812
Other Current Debt	-	-
TOTAL CURRENT BONDS AND NOTES	58,627,424	29,044,612
Noncurrent Portion of Bonds	417,294,813	436,723,003
Noncurrent Portion of Notes	47,386,248	31,622,054
Other Noncurrent Debt	15,473,132	5,742,000
TOTAL NONCURRENT BONDS AND NOTES	480,154,193	474,087,057

As currently constituted, UNC Health Care has no authority to issue debt. Only the individual entities within UNC Health Care have assets and revenue that can be pledged as collateral for the debt.

Annual requirements to pay principal and interest on the bonds outstanding at June 30, 2013, are:

FISCAL YEAR	PRINCIPAL	INTEREST	TOTAL
2014	\$18,968,076	\$12,656,980	\$31,625,056
2015	18,290,000	12,067,645	30,357,645
2016	19,330,000	12,022,635	31,352,635
2017	20,050,000	11,667,624	31,717,624
2018	20,950,000	11,151,200	32,101,200
2019-2023	118,010,000	43,335,439	161,345,439
2024-2028	139,245,000	32,941,874	172,186,874
2029-2033	100,456,924	13,321,857	113,778,781
2034	2,710,000	70,500	2,780,500
TOTAL	\$458,010,000	\$149,235,754	\$607,245,754

Annual requirements to pay principal and interest on the notes outstanding at June 30, 2013, are:

FISCAL YEAR	PRINCIPAL	INTEREST	TOTAL
2014	\$7,459,348	\$1,640,963	\$9,100,311
2015	5,247,694	1,465,303	6,712,997
2016	3,895,315	812,188	4,707,503
2017	2,494,985	579,352	3,074,337
2018	2,595,439	548,030	3,143,469
2019-2023	25,896,774	2,267,541	28,164,315
2024-2028	2,602,714	15,590	2,618,304
2029-2033	4,653,327	0	4,653,327
2034	0	0	0
TOTAL	\$54,845,596	\$7,328,967	\$62,174,563

NOTE 5 // PENSION PLANS

UNC Health Care has a variety of retirement plans available to its permanent full-time employees. The majority of employees of UNC Hospitals and UNCFP are members of the Teachers' and State Employees' Retirement System (TSERS) as a condition of employment. TSERS is a cost-sharing, multiple-employer defined benefit pension plan established by the State to provide pension benefits for employees of the State, its component units and local boards of education. The plan is administered by the North Carolina State Treasurer. Graduate medical residents, temporary employees and permanent part-time employees with appointments of less than 30 hours per week are not covered by the plan.

The Optional Retirement Program (the Program) is a defined contribution retirement plan that provides retirement benefits with options for payments to beneficiaries in the event of the participant's death. Administrators and eligible faculty of the University may join the Program instead of the Teachers' and State Employees' Retirement System. The Board of Governors of The University of North Carolina is responsible for the administration of the Program. Participants in the Program are immediately vested in the value of employee contributions. The value of employer contributions is vested after five years of participation in the Program. Participants become eligible to receive distributions when they terminate employment or retire.

Rex sponsors a single-employer defined benefit retirement plan available to eligible employees. The benefit formula is based on the highest five consecutive years of an employee's compensation during the 10 plan years preceding retirement. There are no employee contributions to the plan.

Funding amounts for all of the plans are based upon actuarial calculations.

In addition to the employer plans, UNC Health Care employees may elect to participate in any number of deferred compensation and Supplemental Retirement Income Plans. These include 401(k) plans, 403(b) plans and 457 plans. All costs of administering and funding the plans are the responsibility of the participants. Rex employees may contribute to a tax-deferred annuity plan through which Rex matches one-half of each participant's voluntary contributions on a graduated scale based on length of service, not to exceed 5 percent of the participant's annual salary.

NOTE 6 // OTHER EMPLOYMENT BENEFITS

UNC Hospitals and UNCFP participate in state-administered programs that provide health insurance and life insurance to current and eligible former employees. Funding for the health care benefit is financed on a pay-as-you-go basis based upon actuarial reports. UNC Hospitals and UNCFP assume no liability for retiree health care benefits provided by the programs other than their required contributions.

UNC Hospitals and UNCFP participate in the Disability Income Plan of North Carolina (DIPNC). DIPNC provides short-term and long-term disability benefits to eligible members of the Teachers' and State Employees' Retirement System. UNC Hospitals and UNCFP assume no liability for long-term disability benefits under the Plan other than their contribution.

Rex offers a full menu of employment benefits to its employees through various third-party carriers. These include medical insurance, dental coverage, short-term and long-term disability benefits, and life insurance coverage.

More information about these plans can be found in the individual audit reports for the various entities.

NOTE 7 // RISK MANAGEMENT

UNC Health Care is exposed to various risks of loss related to torts; theft of, damage to and the destruction of assets; errors and omissions; employee injuries and illnesses; natural disasters; medical malpractice; and various employee plans for health, dental and accident. These exposures to loss are handled by a combination of methods, including participation in state-administered insurance programs, purchase of commercial insurance and self-retention of certain risks. There have been no significant reductions in insurance coverage from the previous year.

Liability Insurance Trust Fund – UNC Hospitals and UNCFP participate in the Liability Insurance Trust Fund (the Fund), a claims-servicing public entity risk pool for professional liability protection. The Fund acts as a servicer of professional liability claims, managing separate accounts for each participant from which the losses of that participant are paid. Although participant assessments are determined on an actuarial basis, ultimate liability for claims remains with the participants and, accordingly, the insurance risks are not transferred to the Fund.

Additional disclosures relative to the funding status and obligations of the Fund are set forth in the audited financial statements of the Liability Insurance Trust Fund for the Years Ended June 30, 2013, and June 30, 2012. Copies of this report may be obtained from The University of North Carolina Liability Insurance Trust Fund, 211 Friday Center Drive, Hedrick Building - Room 2029, Chapel Hill, N.C., 27517.

NOTE 8 // ESCROW FOR CERTIFIED PUBLIC EXPENDITURES (CPEs)

With the help of the North Carolina Hospital Association, UNC Health Care has entered into an agreement with other public hospitals in North Carolina to receive the benefit of additional Certified Public Expenditures (CPEs). By making additional CPEs available, the public hospitals risk possible Disproportionate Share Hospital (DSH) overpayments that would require repayment to state or federal agencies. In order to mitigate the public hospitals' risk, UNC Health Care established a reserve fund to be held in escrow. This fund will reimburse participating public hospitals for any repayments that should result from this program. The UNC Health Care System Enterprise Fund transferred \$14,844,132 to the Escrow Agent, First-Citizens Bank & Trust Company.

NOTE 9 // RELATED PARTY TRANSACTIONS

The Medical Foundation of North Carolina, Inc. – UNC Hospitals and UNCFP are participants in The Medical Foundation of North Carolina, Inc., a nonprofit foundation for The University of North Carolina at Chapel Hill and UNC Hospitals, which solicits gifts and grants for both entities. The Board of Directors of the Medical Foundation administers the funds of the Foundation. Transactions are recorded only by the Foundation. If the Foundation were to purchase any equipment for UNC Hospitals, then the amount would be recorded at the time of receipt on UNC Hospitals' financial statements.

UNC Health Care System Enterprise Fund – The Board of Directors of UNC Health Care authorized and approved the creation of the UNC Health Care System Enterprise Fund (the System Fund) to support UNC Health Care's mission and vision to be the nation's leading public academic health care system. Pursuant to a memorandum of understanding effective July 1, 2005, UNC Hospitals, UNCFP, Rex and the UNC School of Medicine agreed to finance the Enterprise Fund. The System Fund enables fund transfers among entities in the health system in support of the Board's vision to be the nation's leading public academic health care system.

The System Fund assesses, holds and allocates funds across the entities of UNC Health Care. Initially formed as the Enterprise Fund to facilitate investments in support of the clinical, academic and research missions of UNC Health Care and the UNC School of Medicine, the Enterprise Fund today exists as a sub-account within the System Fund. Since its formation, the System Fund has been used to enable additional types of transfers between entities of UNC Health Care. As such, the Enterprise Fund, Outreach Fund, Patient Safety Fund, Recruitment Fund and Shared Administrative Services Fund each function as sub-accounts of the System Fund.

Henderson County Hospital Corporation d/b/a Margaret R. Pardee Memorial Hospital (HCHC) – Henderson County is the sole member of HCHC, a North Carolina not-for-profit corporation, which is in turn the sole member of Henderson County Urgent Care Centers, Inc., and Western Carolina Medical Associates, Inc. HCHC was created by Henderson County to provide for the operation of a community hospital in Henderson County, N.C., that is dedicated to serving the health care needs of Henderson County citizenry. These facilities include 201 licensed acute care beds, 21 licensed psychiatric beds, a physicians' services group, a home health agency and an urgent care center, which provides a variety of community-based services.

On June 22, 2011, HCHC signed a management service agreement engaging UNC Hospitals to conduct and effectively manage the day-to-day operations of Margaret R. Pardee Memorial Hospital and HCHC's affiliated operations over a term of 10 years. Additionally, the Chief Executive Officer of HCHC is an employee of UNC Health Care.

A new management service agreement was entered into on Sept. 4, 2013, engaging UNC Hospitals to conduct and effectively manage the day-to-day operations of Margaret R. Pardee Memorial Hospital and HCHC's affiliated operations over a term of 25 years.

The John Rex Endowment – The John Rex Endowment (the Endowment) operates as a 501(c)(3) corporation and is independent of the Board of Directors of UNC Health Care. Its purpose is to advance the health and well-being of the residents of the greater Triangle area, with specific funds set aside for indigent care and to make grants to support health services, education, prevention and research. In discharging its purposes, priority consideration will be given to any funding requests from Rex, UNC Health Care and their affiliates. The funding source for the Endowment is the \$100 million transfer that came from UNC Health Care in April 2000.

NOTE 10 // COMMUNITY BENEFITS

In addition to providing care without charge, or at amounts less than established rates to certain patients identified as qualifying for charity care, UNC Health Care also recognizes its responsibility to provide health care services and programs for the benefit of the community, at no cost or at reduced rates. UNC Health Care sponsors many community health initiatives, including breast and prostate cancer screenings, cardiovascular and pulmonary awareness, and diabetes education programs that ultimately result in the overall improved health of our community. UNC Health Care also provides contributions, cash and in-kind, to various charitable and community organizations. The costs of these programs are included in operating expenses in the accompanying *pro forma* statements of revenues and expenses.

UNC Health Care and its entities participate in the North Carolina Hospital Association's (NCHA) Advocacy Needs Data Initiative (ANDI) to quantify their Community Benefit. As was the case in prior years, the data for calculating the FY13 Community Benefit remains fluid, and will be included in NCHA's ANDI report in spring 2014.



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